State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Jonth 3:45 AM. Physician 2007 Madeline Mary Cohen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pattingre washing to medical centers. Social Security Number 6. Sex 7. Age (In yrs. last birthda If Under 1 Year Burnie ear I If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Director 214-48-2192 94 Aug. 24, 1912 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Bel Air Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 300 Glenwood Road 21014 **USA** Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: ģ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Many Injury or other traumatic event, the Mones. 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie (unk) Christianson Carl (unk) Schneider ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7643 3rd Avenue, Glen Burnie, Maryland 21060 Marlene E. Richardson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-16-07 Garrison Forest Vet Owings Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** nenmon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner r Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: No CA Inpatient မ 1 ☐ Yes 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28a. 28b. Time of 28d. Describe how injury occurred Medical Certification: After Notified 24 hours after death. To the Funeral Ulrector: After the Funeral Ulrector in the Funeral Ulrector in the farth of the farth o 5 ☐ Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

Registrar DHMH 17 Rev 1/2001

State

2

29a. Certifier

(Check only one)

0. Name and addre

31. Date filed (Month, Day,

29b. Signature and title of certifier

M

s on, erson who completed gauss of death (Item 23a) (Type, Frint)

32.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and matrix as sauce.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Maryla		artment of H			ene	1	23002
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
100	Physici /Medic		Raymond Benard (Cuffley Sr.			•	July 14,		Teal	12:50 A ^M
	Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or			4c. County		
		A	509 Green Street			Havre de	e Grace If Under 24 Hrs.	1	Har:	ford	
	Funeral Director		5. Social Security Number 6. Sex	4 2 T E	i. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 3,	^{Year)} 1930	Country.	
	<u> </u>		216-28-4130 Usual Residence of Decedent		76 Yrs.			Aug. 3,	1930	тату.	Land
	ylanc		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10	d. Inside City Limits
	e Ma	cto	Maryland Harford	Ha	avre de						1 XYes 2 No
	ith th	Director	10e. Street and Number			10f. Zip Code			g. Citizen of W	Vhat Count	y ?
	s 23e	ral	509 Green Street	. Was Decedent Ever in	11.6	21078 Was Decedent of Hi	anania Origina (Si		JSA 14 Bace	e - America	n Indian
	ter de Itam	Funeral	11. Marital Status 12 Married 12 Married	Armed Forces? 1 Yes 25 No	0.5.	f Yes, specify Cuba	n, Mexican, Puert	Rican, etc.)		k, White, e	
980	urs af al', or	þ	3€ Widowed 4 Divorced	If Yes, Give Year or Dates:		1☐ Yes 2DXNo	Specify:		Specify	·· W	hite
2-0	within 72 hours after death with the Maryland liene. rthan "natural", or Itama 23a or 28a-1 show the Medical Examener must be contilled at	Completed	15. Decedent's Educa (Specify only highest grade of		16a. Dece	dent's Usual Occupa	ation furing most of wor	kina 1	6b. Kind of Bu	usiness/Indu	ustry
21		nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)				
2	e filed within Il Hygiene. other than vent, the Me		17. Father's Name (First, Middle, Last)		Truck	Driver	18 Mother's Nam	ne (First, Middle, M	State		ryland
anc	Q 22 D	Be		ley Sr.						•	
Maryland 21215-0036	s 1 and 2 should be f Health and Mental itam 27 is marked other traumatic ev	ပ	Dewey Leroy Cuff 19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street a		Catherine			
	nd 2 ith a 27 ts		Clara C. Hall / Da	ughter	509	Green Str	eet. Hav	re de Gra	ice. MD	2107	8
Baltimore,			20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place		Date 2	Oc. Location -	City or Tov	vn, State
Ē	Pages nent of I ant: If its ury or o		1 ⊠Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)		ngel Hi	11 Cemete	rv 7-18	-07 I	lavre d	e Gra	cc. MD
Salt	permit. Page Department of Important: If any injury or ance.		21. Signature I pneral Service Licensee		22	Name and Address F	uneral H	ome, P.A.			17.
	₹ □ = a		1914 (11)	wys		1317 Coke	sbury Ro	ad, Abing	don, M		09 Approximate
Н			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	cause on each line.				or respiratory arre	SI,	1	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			r accide	12			2	voith's
8	Examiner			Due to (or as a conse	equence of):						
华		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):						
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
ő,	be executed icien and burial-transit	EX	resulting in death) Last	Due to (or as a conse	equence of):						
8760,	e Xs	dical	d.								
9 X	The law requires that the death certifica ste has been signed by the attending ph bage 2 should be detached for use as the	/Med	IF FEMALE: 230	. If yes, outcome of pregi	nancv				23d Dat	te of deliver	v
Вох	atten for u	clan	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)			Moi		Day Year
P.O.	that the dened by the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
	res that igned b	by PI	Part II. Other significant conditions contr	ibuting to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use cont	ribute to the	e cause of death?
Ž	w require been sig should b		<u>Curunary</u> outer	7 Cisease				1 □ Ye	s 28 No	3 🗌 Proba	bly 4 □Unknown
Vital Records	e law re has be je 2 sho	Completed	Non-Insolin Del	rendant Dia	cheles V	hellites		24a. Was an autopsy		Were autop	sy findings available
α.		Com	,					perform 1 ☐ Yes 3	ed?	death?	2 No
/ita	sicien: T certifical rector, p	Be	25. Was case referred to medical examiner?			Tour		th Check only one			
of	w 5	10	1 Yes 2 No		ER/Outpatier		4 Unursing n	ome 5X Resider)
Division of	ding h. After fune	tlon	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Worl	(? Yes 2 □No	200. 20000000	W Injury Coods	160	
/isi	of or Attending after death. I Director: After d in by the fune	flca	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, sti	eet, factory, office		28f. Location (Str		er or Rural	Route Number,
ă	s atte	Certification:	4 Homicide determined	building, etc. (Spec	olly)			City or Town,	, State)		
	To the Hospitel or Attenwihin 24 hours after deall To the Funeral Director: completely filled in by the	edical		r: To the best of my kir: On the basis of examinand manner stated.							
	To the within To the comple	Me	29b. Signature and title of certifier	n		29c. License	e number	29	d. Date signe	d (Month, E	Day, Year)
			I peased the	le MO		P004	(2050		7/16/	07	
	6/		30. Name and address of person who com	pleted cause of death (Ite	em 23a) (Type,	Print)	- A C I		9		
	7		1 STORY STORES	on 15 s. Pa	alco Str	cet + Tu	Moerd	eenmo	2100		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	And .					
	78 W Mr 20 95	+ 1	50 m 1 0 m	A. S. M. 18 18 18 18	El A	STEEDER!					

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2007 23003

,	1- For State Cert Registrar	ificate of Death	Reg. No.			
Physician/	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death		
ledical Examine	DIMBI EDWING		July 8, 2007 4c. County of Deat	0843 hrs		
	Facility Name (if not institution, give street and number) 1705 Columbia Avenue	4b. City, Town, or Location of Death Seat Pleasant	Prince Georg	Prince George's		
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. la:	st birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Forei	gn WASHINGTON		
Director	578-70-3738 1XM 2 F 54	Yrs.	DEC 17 1952 G	ountry) DC		
ž.	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits		
ow any		YATTSVILLE		1 X Yes 2 No		
ne Maryland or 28a-f show lied at once. Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?		
the Maryland or 28a-f sh iffied at once	1705 COLUMBIA AVENUE	20785	U.S.A.			
with the s 23a is 23a				rican Indian, Black,		
leath with r items 23 nust be no	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.			
ral", or	3 V Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specify: BL			
hours		16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti		s/Industry		
-0036 within 72 hour giene. her than "natue tandiral Exance of the text of th	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 th	YOUTH COUNSEL	OR GOVER	NMENT		
d with giene filter ther there	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)			
21215-0036 Mental Hygiene. Mental Hygiene ananked other than "mate event, the Medical Exa	WADE CLARK SR.		BELL			
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F				
nore, MD 2 ages 1 and 2 shou nt of Health and 1 tt: If iten 27 is in other transmatic	MOLLIE CLARK/MOTHER	#15 RIGGS ROAD N.E. W	Date 20c. Location - City of			
ore, ME es 1 and 2 s of Health au If item 27 her traums	1 3 Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, rematory or other place)				
Baltimore, permit Pages La Department of He Important: If ite	Totalen e Totalen	SURRECTION CEMETERY 7/				
Salt ermit Depart mpor njury	21. Signature of Funeral Service Licensee	22. Name and Address of Facility J.				
	23a. Part I. Enter the disease, or complications that caused the death.		AD LANDOVER, MARYLA or respiratory arrest, shock, or heart	Approximate Interval		
Physician /Medical	failure. List only one cause on each line.			Between Onset and Death		
kaminer	Immediate Cause (Final disease or condition resulting in death) a. Narcotic intoxic Due to (or as a consequence of					
	Sequentially list conditions, b					
led Insit	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause):				
\$	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
'60, ate be execuphysician and the burial - tr	X UNPENDED AMENDED #23a, PTI, 27, 28a-	f. perME.g869m 7/25/07 TT	00d Date of deliv			
8760, iificate be ng physic as the bur		nancy 2 Fetal death 3 Ectopic pregna	23d. Date of deliverancy Month	Day Year		
Box 687 death certific the attending of ed for use as the	Do Not become the pregnant in the past 12 months? 1 Live birth Pregnant at time of de					
D. Bc the dea by the a	Part II. Other significant conditions contributing to death but not re	position in the underlying cause given in Part I	23e. Did tobacco use contribute	to the cause of death?		
P.O. E es that the d igned by the oe detached	Cirrhosis of the liver	esulting in the underlying cause given in rate.	1 Yes 2 No 3 P			
ords, Pw requires to w requires to seen sign should be contacted.				autopsy findings available		
COFC law re has be			performed? death			
Division of Vital Records, rat or Attending Physician: The law requirers after death an Director. After this certificate has been s facility the funeral director, page 2 should be the facility of the facili		26.Place of Death (Check	1 Yes 2 No 1 V	Yes 2 No		
Vital ysician his cert directo	examiner?	Other	ng Home 5 Residence 6 ✔ Ot	her: Scene		
ding Physi After this funeral dir	27 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred			
on ending auth our. A the fu	1 Natural 5 Pending Fnd 7/8/07	Fnd 8:40 am 1 Yes 2 X No	unk			
VISIOR or Attend fler death Director: in by the	2 Accident Investigation 7 IN 7 O O 28e. Place of Injury - At h	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or or Town, State)	Rural Route Number, City		
Division 24 hours and a streng Pinneral Director: stely filled in by the	1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) found at		1705 Columbia Ave. Se			
	To 29d. Certifying Physician: To the best of my knowled (Check only one) Wedical Examiner: On the basis of examination a	ge, death occurred at the time, date and place, an nd/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as s at the time, date and place, and due to	stated. o the cause(s)		
To To con	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (i			
	Pat Clam: - Palah	O.C.M.E.	July 9, 2007			
	30. Name and address of person who completed cause of death (Item	1 23a)				
	Patricia Aronica-Pollak MD. Assistant Medical	Examiner 111 Penn Street, Baltimo	re, MD 21201			
Sta Registra		ure				
	TOTAL COURT OF THE	ODIGINAL				
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	State of	Marviario /	Department	UI ITEAILII	and w	entai i i	ygiciii

avid M. Crawford	State of Maryland / Department of Health and N 1-For State Certificate of Death	Reg. No. 2007 2200									
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year 1904 hrs									
Medical Examine	David M. Crawford III 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Local	July 13, 2007									
	Franklin Square Hospital Rosedale	Baltimore County									
Funeral	or decidir decidir, viamos	Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign									
Director	374-18-4671 1X M 2 F 90 Yrs. Months Days	Hours Min. March 13,1917 Country New York									
an X	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits									
*	Maryland Baltimore Perry Hal	1 Yes 2 X No									
the Maryland a or 28a-f show tifted at once. Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?									
with the Maryland ms 23a or 28a-f sho be notified at once eral Director	9906 Gunforge Road 21128	U. S. A.									
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once and by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.									
er deal	3 X Widowed 4 Divorced If Yes 2 No St. Or Dates:	pecify: Specify: White									
urs aft	or Dates: 1941-1902	(Give kind of work done 16b. Kind of Business/Industry									
7 3 - 3	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DC	NO (use retired)									
withir siene.	2 Communications 17. Father's Name (First, Middle, Last) 18.h	Specialist U. S. Army Mother's Name (First, Middle, Maiden Surname)									
215-0036 be filed within 72 rical Hygiene. rked other than " ent, the Medical I		Leslie V. Hill									
D 2121 should be fi and Mental 7 is marked natic event, To Be		d Number or Rural Route Number, City or Town, State, Zip Code)									
e, MD 21 I and 2 should Health and Me item 27 is ma	David M. Crawford IV (Son) 3324 N E 21st A	Avenue, Portland, Oregon 97212									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	1 Burial 2 X Cremation 3 Removal from State crematory or other place)										
Itim iit. Pa artmen ortant ry or c	4 Donation 5 Other Specify: Bayview Crematory 21. Sign rure of Funeral Service Licensee 22. Name and Address of	07/17/2007 Baltimore, Maryland Facility Schimunek Funeral Home Inc.									
Balti permit. Departm Imports injury o	19705 Belair	Road, Baltimore, Maryland 21236									
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc failure. List only one cause on each line.	Between Onset and									
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Feeding Tube Placement with Complications Due to (or as a consequence of):	Death									
	Sequentially list conditions, b.										
i	if any, leading to immediate Due to (or as a consequence of): cause: Classes or injury that initiated C.										
Fxaminer	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleanh. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit policical Certification: To Bo Completed by Physician/Medical Examples	d. UNPENDED AMENDED										
60, ate be execut hysician and e burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery									
). Box 6876(the death certificate by the attending phy tched for use as the b	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy Month Day Year									
Box 687 e death certific the attending p ed for use as th	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)										
ires that the de signed by the leaded of detached for the boundary of the boun											
S, P.C.	End stage renal disease, Chronic Obstructive Pulmonary Disease, Congesti	ve Heart 1 Yes 2 V No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available									
Vital Records, I systeian: The law requires this certificate has been sig director, page 2 should be	Failure, Pneumonia	autopsy performed?									
tal Rec		1 Yes 2 No 1 Yes 2 No									
ital sician:	25. Was case referred to medical examiner?	Death (Check only one) 16r4 Nursing Home 5 Residence 6 Other:									
of Viting Physic After this uneral directory	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury 3	at Work? 28d. Describe how injury occurred Subject bled following surgery									
ion tendin leath. tor: A the fu	1 Natural 5 Pending Jul 13, 2007 Pearl 1903 hrs 1 Yes	2 No									
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th ours after death. meral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	3 Suicide 6 Could not be determined (Specify) Hospital	ding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Franklin Square Hospital, Rossville, Md.									
Division Hospital or Attene 24 hours after death Funeral Director: tely filled in by the											
Division of To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Contification: To charing Contification: T	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated. 29b. Signafure and title of pertifier 29b. Signafure and title of pertifier 29b. Date signed										
F. 3 F. 3											
	O.C.M.	E. July 14, 2007									
0+1	30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltim	ore, MD 21201									
Stat	31 Date flood (Month Day York) 32 Registrat's Signatures										
Registra	JUL 1 8 2007 Personal Strategy of Strategy										

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of M	aryland /	-		lealth and M	lental Hyg	jiene		
			Registrar		Cer	tificate of L	Death		leg. No.	007	22005
	Physicia	an	1. Decedent's Name (First, Middle, Last) Zaiyon A. Clay					2. Date of Dea	Day	Year	3. Time of Death
-	/Medic		4a. Facility Name (If not institution, give street and number)			4h City Town or	Location of Death	July	4c Cour	ZOO7	22: 35 M
I.	Examin	er	The Johns Hopkins Ho	Spita	1	Rol	timeso l	city	10.000	ity of Death	
	Funeral		5. Social Security Number 6. Sex 7. Ac	e (in yrs. last i	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	Vone)	9. Birthp	lace (State or Foreign
	Director		1X M 2 F		Yrs.	Months Days	Hours Min.	July 4,	2007	Cour	MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	eation				1	0d. Inside City Limits
	f sho	ō	MD	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Balti	more				1y⊠Yes 2 □ No
	the 28a-	Director	10e. Street and Number	<u></u>		10f. Zip Code		1	10g. Citizen o	of What Cour	itry?
	be filed within 72 hours after death with the Maryland ntal Hygiene. od other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	al D	1621 East Madison Street				21205		U	SA	
	ems ar mu	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of Hi	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		ace - Americ lack, White,	
õ	or Ite	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 次			☐ Yes ŽŽ No	Specify:	r noun, cic.)	Spec	Afri	
2-003p	hours tural"	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	14	Fo Doord	ent's Usual Occupa	-4:	-		Amer	
င်	in 72	Completed	(Specify only highest grade completed)		(Give H life. D	kind of work done of NOT use retired	during most of work f)	ing	TOD. KING OF	Business/Inc	dustry
7 7	d within giene. r than " the Mec	mo.	Elementary/Secondary (0-12) College (1-4or	D+)		n/a			n	/a	
p	be filed Ital Hygi of other event, til	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surn	ame)	
<u>a</u>	should b nd Menta marked umatic e	To	Trey Clay					Alisha	C. Lewis	s	
a	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print)	1			and Number or Run				*
e où	1 and Health Hm 27 ther t		Dorothy Hall / Aunt 20a. Method of Disposition	20h Blago			on Street;	Baltimore Date	<u> </u>		
more,	Pages nent of H int: if Ite		1 Burial 2 □ Cremation 3 □ Removal from State			sition (Name of natory or other place			20c. Location	-	
			4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Drui	`	ge Cemetery	07/18/ ss of Facility Wy1		Baltimo:	the state of the s	yland
Balt	permit. Departr Importa any Inj		21. Signature of Fulleran Service Liberisee				th Gilmor S				and 21217
г			234 Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	the death. D	o not ente					, ILILYI	Approximate Interval Between
·	Physician	4	Immediate Cause (Final	ne.							Onset and Death
)	/Medical		disease or condition resulting in death) a. Due to (or as	a consequenc	ce of):	rtorat					s agys
	Examiner		Sequentially list conditions b. Ne	roti	Zin	a en	tero col	itis			3 days
4	p #	iner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. Seg.	a consequenc	e of).)					2 1
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	a consequence	20.00:						3 days
Ď,	icate be executed physician and s the burial-transit	a E	Due to (of as	a consequent	Je 01).						1
08/PN	ificate be executed g physician and ss the burial-transit	edical	d								
ZOZ		M/U	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant						23d. [Date of delive	erv
<u>מ</u>	death cert e attendin ed for use	Physician/M	in the past 12 months? 1□ Yes 2□ No 4□ Pregnant a			Ectopic pregnancy Other (specify)				Month	Day Year
5	at the by th tache	hys	9 ☐ Unknown								
ś	w requires that the de been signed by the should be detached	by F	Part II. Other significant conditions contributing to death to			,		1	bacco use co	ontribute to the	ne cause of death?
ecords,	een s		riematurity, intra	uteri	<u>ne</u> _	growth	retardation	1 1 Y	'es 2 No	3 ☐ Prot	oably 4 Unknown
	The law te has b	Completed						24a. Was a autop	sy	prior to co	psy findings available mpletion of cause of
VITAI H		Co						perfor Yes	med? 2□No	death? 1 □ Yes	2 No
<u> </u>	sician: The law s certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?			Othe	26. Place of Deat				
ō	Physer this eral di	<u>۲</u>	27. Manner of Death 28a. Date of Init	ury 28t	Outpatient b. Time of	3 DOA	4 L Nursing Ho	me 5 Resid			y)
0	th. :: Afte	itior	1 Accident 5 □ Pending (Month, De 2 □ Accident investigation	ny Year)	Injury	28c. Injun Worl	k? Yes 2 □ No		,,		
UNISION	Atter	ifica	3 Suicide 6 Could not be 28e. Place of in	ury - At home, tc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S	Street and Nui	mber or Rura	al Route Number,
5	tal or	Certification:	building, e	ic. (Specify)				City or Tow	n, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to		29a. Certifier (Check only 2 Medical Examiner: On the basis of	of my knowled	dge, death	occurred at the tin	ne, date and place,	and due to the	cause(s) and	manner as s	tated.
	the l	Medical	one) and manner st	ated.							
	N L O		29b. Signature and title of certifier			29c. License	c number		29d. Date sig	nea (Month,	Day, rear)
	10		1 Wenne Kell	to ath (It = == 00	a) (T.: '	Deline)	5 2 - W	UU	70	1 y 1.	2 200/
) (30. Name and address of person who completed cause of	L p	a) (Type, I	-cet	Baltin	rore	Mary	land	21287
	Sta	te		rar's Signature	<u> </u>	-01	UNITIN	יטוב	101019	MITTE	01001
	Registr	ar	JUL 1 8 2007 Man	ene . A	8 1	South a					

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la Cason	1	State of Maryland / Departmer	nt of Health and Ment te of Death	aı Hygiene Reg.	No. 2007 23							
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death							
dical Exami	ner	Darla Cason	4b. City, Town, or Location o	Month May 10, 200	4c. County of Death							
		 Facility Name (if not institution, give street and number) Maryland General Hospital 	Baltimore									
Funeral Director		5. Social Security Number 212–96–3769 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under Months Days Hours		(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)MD							
, any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MD	r Location Baltimore	2	10d. Inside City Lin							
Maryland 28a-f show	Director	10e. Street and Number 2525 Eutaw Place; Apt. 402	10f. Zip Code 21217		g. Citizen of What Country? USA							
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene frem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Funeral Di	11. Marital Status 1 X Never Married 2 Married 2 Married 2 Armed Forces?	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	gin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.							
fter de I'', or i		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		African American							
nours a	ed by	d	Decedent's Usual Occupation (Give uring most of working life, DO NOT	141110 01 114111 0 0 1111	16b. Kind of Business/Industry							
36 iin 72 i isan "r dical E	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	homemaker	E 100 11	domestic							
21215-0036 unld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	ပေ	17. Father's Name (First, Middle, Last)	18.Mothe	r's Name (First, Middle, Maron Cas								
121; d be fil lental P arked	o Be	Joseph Simms 19a. Informant's Name/Relationship (Type, Print) 19b	Mailing Address (Street and Nu	mber or Rural Route Numb	per, City or Town, State, Zip Code)							
MD 2 nd 2 shoul alth and M m 27 is m	Ţ	Deonte Painter / Daughter	2525 Eutaw Place	Apt. 402; Balti	more, Maryland 21217							
re, N 1 and 5 1 Thealth If item er trau		20a. Wethod of Disposition	f Disposition (Name of cemetery, pry or other place)	Date 05/16/2007	20c. Location - City or Town, State Randallstown, Maryland							
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:	Temorial Park									
Balt permit. Depart Impor	Widowed 4 Divorced lives, Give Year or Dates or											
	Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her											
'Medical aminer		Immediate Cause (Final disease a. Subarachnoid hemorrhage due to ruptured cerebral aneurysm										
2		or condition resulting in death) Due to (or as a consequence of): b.	30452									
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	= 1									
t	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
ecuted and - transit	al E	d.										
O, e be exe ysician burial -	g	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery							
6876 ertificat ding phy	sician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death		pic pregnancy	Month Day Year							
J. Box t the death c by the atten ached for us	Phys	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in	Part I. 23e. Did to	bbacco use contribute to the cause of death							
, P.O. res that the signed by be detach	à	,		1 Yes	s 2 No 3 Probably 4 V Unkn							
of Vital Records, ing Physician: The law require Net this certificate has been simely displayed as a should be a should director name 2 should be	plete			24a. Was autop perfo	prior to completion of cause death?							
/ital Recorysician: The law in secutificate has the director, mase 2 sh	S			th (Check only one)								
Vital ysician his cer	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA Other		Residence 6 Other:							
ion of Vi tending Physi eath for: After this	-	27 Manner of Death 28a, Date of Injury 28b.	Time of Injury 28c. Injury at Wo	No	how injury occurred							
Division spital or Attendit ours after death neral Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	farm, street, factory, office building,	, etc. 28f. Location (or Town, S	Street and Number or Rural Route Numbe State)							
Division To the Hospital or Attent within 24 hours after death To the Funeral Directors computative filled in by the	Medical Co		eath occurred at the time, date and investigation, in my opinion, death	place, and due to the cause occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)							
To With	Me	MI Branell MA	29c. License numb	per	29d. Date signed (Month, Day, Year) May 11, 2007							
24		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner	111 Penn Street, Baltim	ore, MD 21201								
2	Stat	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Titl Call Cacci, Balant									
Reg	Stat istra	JUL 1 8 2007 Juguar 19	Grantes									
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			1 - For State Registrar	State of Marylar	-	artment of F <i>rtificate of</i>			giene Reg. No.			
	Dhysisi	9	Decedent's Name (First, Middle, La	est)				2. Date of De		CUU,	3. Time of Death	j
	Physici /Medic		EMILY J. COLBUR					July	16	2007		<u> </u>
	Examir	er	4a. Facility Name (If not institution, giv UNION MEMORIAL			4b. City, Town, o	or Location of Deat	h J	4c.	County of Deatl	h	
	Funeral		5. Social Security Number 6. S		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th ,	9. Birth	nplace (State or Foreig	n
ì.	Director		212-12-9312	1□M 2XF	95 Yrs.	Months Days	Hours Min.	(Month, Da 5-23-1	912	MAR	YLAND	
	and **		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits	_
	Maryl -f sho fied a	ţō	MD. N/A	1	BALTIMO	RE					1X Yes 2 □ No	
	th the or 28a e noti	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	untry?	
	ath wi	ral	911 WICKLOW RD.			2122				USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODCE.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2🌠 No	dispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.))-	14. Race - Amer Black, White Specify: B		
9	72 hou natura ical E	ted	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	oation	ud dan m	16b. Ki	nd of Business/I	ndustry	
21215-0036	ithin 7 ne. han "r e Med	uple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	d) most of wor	rking				
2	filed w Hygie ther th		-12- 17. Father's Name (<i>First, Middle, Last</i>	-0-	CLE	CRK	18. Mother's Nar	ne (Firet Middle		VERNMEN	T	
au	lid be lental ked o ic eve	To Be	HOWARD D. BRENT	•				IA CLASH		ourname)		
Maryland	shou and N is mar	-	19a. Informant's Name/Relationship (**		ng Address (Street						
<u>ک</u>	l and lealth m 27		CARLEEN MCPHERS				EPHENS C				, MARYLAND	
Baltimore,	ages 1 nt of H i: If ite		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	cemetery, crei	osition (Name of matory or other place		Date		cation - City or		
Ħ	nit. Pa artme ortani injuny		4 ☐ Donation 5 ☐ Other (Special 21. Signalure 14 ☐ moral 3 ryice Licer			EMORIAL Name and Addre					MARYLAND P.A.	
ä	Dep any onc) fautt	O. Air							YLAND 2121	7
			23a. Part . Enter the disease, or com shoot or heart failure. List only	one cause on each line.	th. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between	
1	Physician "		Immediat Cause (Final disease or condition resulting in death)	a Pheumo	nia						Onset and Death	
	/Medical Examiner		Toolaining in docum	Due to (or as a consec		art fa		3			LUPCIN	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to ras a conse		Cr 7 16	CT CCCT C				1 9 2011	_
	scuted nd transit	Examiner	Cause. Enter Orliderlying Cause (Disease or injury that initiated events resulting in death) Last	c								
60,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a consec	quence of):							
68760,	ficate physics the	edical		d								_
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			2	23d. Date of deli	very	
	e deat	Physician/M	in the past 12 moviths? 1 □ Yes 2 III No 9 □ Unknown	4☐Pregnant at time of o		Other (specify)	у			Month	Day Year	
0.0	that the	Phy	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?	-
Vital Records,	w requires that the de been signed by the should be detached	d by						1 🗆	Yes 2[□ No 3 □ Pro	bably 4 Dunknown	1
000	aw rec	Completed						24a. Was		24b. Were aut	topsy findings available	
ž		E O						auto perfo 1∐ Yes	psy ormed? 2∐No	death?	ompletion of cause of 2 □ No	
Vita	Physician: The la this certificate har ral director, page 2	a	25. Was case referred to medical examiner?	Hospital:		10"	26. Place of Dea	ath (Check only o				
	Attending Physician: r death. ector: After this certification the funeral director, by the funeral director, it	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time of		4 ⊔ Nursing H	lome 5 Resi			ify)	
<u>0</u>	tending Phy leath. tor: After thi the funeral o	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	f 28c. Injur Wor M 1 🗆	ḱ? Yes 2∐No			y occurred		
Division or	7 te 5	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of injury - At h building, etc. (Speci		eet, factory, office		28f. Location (City or To			ral Route Number,	
	pital o		29a. Certifier 1 Certifying Ph	nucleion. To the heat of mules	ouledes death							41
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only one)	nysician: To the best of my kno nîner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	opinion, death occu	e, and due to the urred at the time,	date and	and manner as I place, and due	stated. to the cause(s)	
	within Comp	Me	29b. Signature and title of certifier	^		29c. Licens	e number		29d. Date	e signed (Month	, Day, Year)	
1	1		(breen K	· Lames	MD		43896	16	July	116,2	007	
	0		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Print)	n Men	assis	и	nenil	Z (NAT	\
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	UVIIO	ri IVIEVI	rioria	1/	OSPIN	11 , 1011	,
	Registr	ar	JUL 1 8 2	2007	H A	call B						

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5, perFH,0869, 7/31/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 7:15 Ам Susan Dale Dunham Julv 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 213-30-9890 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1□ M 2 F 48 Vrc Director 11-28-1958 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD Baltimore Lutherville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 8622 Chelsea Bridge Way 21093 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Management Marketing Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it once, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Edward Franklin Arniel ဥ Doris Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Dunham/Daughter 1201 Doragen Court, Lutherville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/21/2007 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reast years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 M No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) NOSPICE 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital of Attendent within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES M 5/01 31. Date filed (Month, Day, Yea Year) 32. Registrar's Signature State Registrar

07-05359 S

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ean Douglas		State of Maryland / - For State		tment of He <i>ificate of De</i>			j. No.	07 2200			
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death			
Medical Examin		Sean 4a. Facility Name (if not institution, give street and number)		Douglas Tab Ci	ty, Town, or Location o	Month July 13, 20	07 4c. County of Deat				
Ť.		Johns Hopikns Hospital			Itimore		NA				
Funeral Director		5. Social Security Number 6. Sex 7. Age 1216-88-9254 1X M 2 F	(In yrs. las		Under 1 Year If Under onths Days Hours		(MM/DD/YYYY) 9. Bi Forei C				
		Usual Residence of Decedent						10d. Inside City Limits			
w any		,	loc. City, 1	own or Location				1 Y Yes 2 No			
ie Maryland or 28a-f show <u>fied at once,</u>	핡	Md. NA		Baltimon	Zip Code	10	10g. Citizen of What Country?				
th the Maryland 23a or 28a-f sho	Director	3308 McElderry Street			21205		USA				
death with the Maryland or items 23a or 28a-f she must be notified at once	— L	11. Mantal Status 12. Was Decedent Armed Forces? 1 Yes 2			cedent of Hispanic Orig pecify Cuban, Mexican	14. Race - Ame White, etc.	erican Indian, Black,				
after d	by F.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No	1 Yes	2 X No specify:			lack			
hours "natur		15. Decedent's Education (Specify only highest grade com	· ·		ual Occupation (Give working life, DO NOT		16b. Kind of Business	s/Industry			
	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)	Unemp	loved		NA				
5-0036 led within 72 Hygiene. other than '	탉						laiden Surname)				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	a B	Gregory	Doug	las	Et	thel	Bennet	t			
Me Me		19a. Informant's Name/Relationship (Type, Print)		5.1		nber or Rural Route Num					
E B E E		Gregory Douglas Fathe 20a. Method of Disposition			Name of cemetery,	reet Apt. 3,	20c. Location - City				
Baltimore, Normanne, Repertment of Health Important: If item		1 X Burial 2 Cremation 3 Removal from Sta	te cr	rematory or other pl	ace)						
Baltimo permit. Page Department of Important: injury or oth	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Tr	inity Cer	and Address of Facilit	7-20-07	Dundalk,	MO.			
Bal Bal Depa Impo		Dlades Warre	\sim			March F.E Avenue, Bal		d. 21202			
Physician	\exists	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death.	Do not enter the mo	ode of dying, such as o	ardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and			
/Medical aminer	1	Immediate Cause (Final disease a. Sarcoidosis	5					Death			
(- 1	or condition resulting in death) Due to (or as a conse	quence of)):							
	Ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	quence of)):							
9	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C. Due to (or as a conse	guence of								
الله الله الله الله الله الله الله الله		events resulting in death) Last Due to (or as a conse	querice or,	,-							
e execu	Medical	X UNPENDED AMENDEB 7, pe	-ME.28	70. 8/22/07	TT						
760, cate be physic	ğ	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery									
tox 6876 eath certificate attending phy for use as the	sician/N	23b. Was decedent pregnant in the past 12 months?	Month	Day Year							
Box death he atte	ysic	1 Yes 2 No 9 Unknown 9 Unknown		5 Other	(Specify)						
D.O. Be that the de- ned by the a detached fe	y Phys	Part II. Other significant conditions contributing to death	but not re	sulting in the under	lying cause given in P			to the cause of death?			
ords, P.C w requires that as been signed b	ed by					1 Yes		robably 4 Unknown autopsy findings available			
ord:	Completed					24a. Was a autop perfor	sy prior t	o completion of cause of			
Division of Vital Recc pital or Attending Physician: The lav ours after death. Interior: After this certificate ha filled in by the funeral director, page 2	S.					1 Yes					
tal Rectian: The certificate ector, page	Be	25. Was case referred to medical examiner? Hospital:			26.Place of Death		B				
f Vi Physi er this	۵	1 ✓ Yes 2 No		ER/Outpatient 3			Residence 6 Ott	her:			
in of inding Ph	ë	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Inju (Month, Day,Y	ear)	200. Time of injury	1 Yes 2	_	,2.,				
isio	icat	2 Accident Investigation 28e, Place of In	jury - At ho	ome, farm, street, fa	ctory, office building, e			Rural Route Number, City			
Div ital or ral Di	Certification:	3 Suicide 6 Could not be determined (Specify)				or Town, S	tate)				
Divis Hospital or A 24 hours after Funeral Directely filled in b		29a. Certifier 1 Certifying Physician: To the best of m	y knowledg	ge, death occurred	at the time, date and p	lace, and due to the caus	e(s) and manner as s	tated.			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination ar	nd/or investigation,							
	ž	29b. Signature and title of certifier			29c. License number	r	29d. Date signed (/	Month, Day, Year)			
		my m. ms			O.C.M.E.		July 14, 2007				
Ø		30. Name and address of person who completed cause of c Ling Li, MD Assistant Medical Examine			Baltimore, MD 21	201					
	ate	31. Date filed (Month, Day, Year) 32. legistra	r's Signatu	re							
Regist		JUL 1 8 2007 Straw	لكر م	Sport							
DHMH 17 Rev 1/20	001	00115		ORIGINAL							

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AMEND TITEM#5 professioned of Heath and Mental Hygiene

			For State Registrar	State	or Maryla		artment o				giene Reg. No. 2 (107	23010	
	5 .	े	Decedent's Name (First, Midd	le, Last)						2. Date of Dea	ath	101	3. Time of Death	
	Physici /Media		Edward R. Eyler	r, Jr.						July 1	7, 2007	Year	6:00 A.M	
1	Examir		4a. Facility Name (If not institution	n, give street and	number)		4b. City, Tov	vn, or Locatio	n of Death					
1			3301 Traceys M				Manchester				Carroll			
	Funeral Director		5213-34-0470 215-34-0548	6. Sex 12XXM 2□ F	7. Age (In yrs	s. last birthday)	If Under 1 Y Months D	ear If Und ays Hours	er 24 Hrs. s Min.	8. Date of Birt (Month, Da Feb 3	h V. Year) 1936	Cou	olace (State or Foreign ntry) Sylvania	
	land w		Usual Residence of Decedent 10a, State 10b, County	/	10c. 0	City, Town or Lo	ocation						10d. Inside City Limits	
	he Mary	Funeral Director	Maryland Carro	011	М	anchest							XXYes 2□No	
	with t	급	3301 Traceys M	ill Bood			10f. Zip Co				10g. Citizen of Jnited			
	leath	era	11. Marital Status		ecedent Ever in	U.S. 13		102	Origin? (Spe		of Amer	ica ce - Ameri	can Indian	
39	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Ptyglene. Important: If item 27 le marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner coust he restlined at once.	by Fun	1 Never Married 2 Mar	rried Armed	Forces?	1	If Yes, specify			ecify Yes or No Rican, etc.)	Speci	ack, White,		
21215-0036	2 hou	ted	15. Deceder	nt's Education		16a. Dece	dent's Usual O	ccupation			16b. Kind of I			
215	thin 7	npie	(Specify only higher Elementary/Secondary (0-12)		e (1-4or 5+)	lite.	kind of work d DO NOT use r	one during m etired)	ost of worki	ng				
	ed wi	Completed		1,		Gen	eral Ma	T			Von Pa		lovers	
Maryland	be fill d oth	Be	17. Father's Name (First, Middle,							(First, Middle,		me)		
ž	hould d Mer narke	2	Edward R. Eyler			105 11-11	444 /0			June K			2 (1)	
<u>8</u>	id 2 s ith an 27 le		Anne H. Eyler							Manah			and 21102	
ē,	S 1 er		20a. Method of Disposition			Place of Dispo	sition (Name	of	July		20c. Location			
Ē	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 □Removal fro	om State Me	cemetery, cre etro Cr			2007	18,	Catons	ville	, Maryland	
Baltimore,	partm portm porte v inju		21. Si inature of Funera Service	. / /		2:	2. Name and A	ddress of Fac	cility			V111C	, raz į zaria	
m	Depa Impo		N SAM COMM	aun).		3	ckhardt 296 Cha	: Eune: ermil	ral Cr Drive:	napel, H	P.A. ester	Marvl	and 21102	
			23a. Part Enter the disease, o shock, or heart failure. Lis	r complications that only one cause of	at caused the de	ath. Do not en	er the mode of	dying, such	as cardiac o	or respiratory ar	rest,		Approximate Interval Between	
-	Physician		Immediate Cause (Final disease or condition		(0	dan (and	ron				9	Onset and Death	
200 400 300	/Medical Examiner)	disease or condition resulting in death) a. Due to (or as a consequence of):											
	- Adminior	_	Sequentially list conditions,	b	to for on a break	and the second								
	ted nsit	Examiner	Sequentially list conditions, any leading to in modals cause. Enter Underlying Cause (Disease or injury	<	to (or as a confi	adinavue on).								
^	al-tra	xar	that initiated events resulting in death) Last	c. Due	to (or as a conse	equence of):								
8760,	icate be executed physicien and s the burial-transit	dicai		d										
9		edic			-04.4. H									
ŏ	th cert endin r use	M/UR	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome of preg		⊒Ectopic pregn	2001			23d. D	ate of deliv	өгу	
P.O. Box	The law requires that the death certifi ate has been signed by the ettending cage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No	4□Pre	egnant at time of		Other (specif				M	lonth	Day Year	
<u>Ч</u>	d by t	Phy	9 Unknown		-					00- P:44				
ds,	signe d be d	1 by	Part II. Other significant conditi	ons continuiting to	o death but not re	esulling in the u	nderiying caus	e given in Pai	π ι.	239. Dia to			he cause of death?	
Ö	w requir been si should	etec												
Re	he lav	Completed								24a. Was autop	an 24b. sy rmed?	. Were auto prior to co death?	opsy findings available impletion of cause of	
ā	iclen: Th certificate ector, pag	ဝိ	25. Was case referred to medica				-			1 ☐ Yes	2 🗷 No	1 ☐ Yes	2 No	
>	Physiclen: r this certifica ral director, i	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	☐Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Other		me 5 Resid		har /Spec	6.1	
0	ding Phye	T :U	27. Manner of Death	28a. Da	ite of Injury fonth, Day Year)	28b. Time o		Injury at Work?		28d. Describe I			(9)	
<u>Ö</u>	Attending r death, ector: After by the fune	atic	2 - 100.00.11	igation	onar, bay rour	Injury	М	1 Yes 2	□No					
Division of Vital Records,	al or Attendates after deat	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	pined 286. Pla	ace of Injury - At aiding, etc. (Spec	home, farm, str cify)	reet, factory, of	fice		28f. Location (5 City or Tox	Street and Num vn, State)	ber or Rur	al Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death, To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Certifyi 2 Medical	ng Physician: To Examiner: On the and m	the best of my kr basis of examination	nowledge, deat nation and/or in	h occurred at the vestigation, in	ne time, date my opinion, d	and place, leath occurr	and due to the ed at the time,	cause(s) and n date and place	nanner as s , and due t	stated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certific	er (29c. Li	cense numbe	er .		29d. Date sign	ed (Month,	Dey, Year)	
-	/		1 to be	ocha	TM.		Do	2036	112		7-17	-07	2	
	6		30. Name and address of person				Print)				Rock		20 8	
)			woods			stead.	md 2	1074	D.A	Koch	na	17), D,	
	Sta Registr		31. Date filed (Month, Day, Year	9 2007	l. Registrar's Sign	nature	1-N-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 July 15, Gertrude E. Easton 6:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air 501 Mauser Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 💢 F 91 13,1915 Maryland Director 216-07-7364 Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County a or 28a-f show be notified at 28a-f show 1 ☐ Yes 2 No Director Harford Bel Air Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a the Medical Examiner must b U.S.A. 21015 501 Mauser Drive Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: þ White 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Ice Cream Company Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Gormon Little Laura Green Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a item 27 is rother tra 501 Mauser Dr., Bel Air, Maryland 21015 Sherrie Myer (Granddaughter) altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ₽ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State P Department of Important: If any Injury or once. 4 Donation 5 ☐ Other (Specify) 07/20/2007 | Baltimore, Maryland Parkwood Cemetery 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 🗸 0 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy pade perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No Director: / 6 Could not be determined

within 24 hours at To the Funeral C completely filled it

DHMH 17 Rev 1/2001

3 ☐ Suicide

29a. Certifier

Medical

State

Registrar

4 Homicide

(Check only one)

29b. Signature and title of certified

gn 31. Date filed (Month, Day,

Year)

8

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar's Signatu

Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 15, 2007 **Physician** 7:30 PM Kathleen Marie Fawns /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6230 Glen Valley Terrace Frederick Frederick Unit C If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 □ M 2 X F 1955 Pennsylvania Jan 20, Director 188-46-7991 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland or 28a-f show notified at 10a. State 10h County 1 ☐Yes 2 X No Director Frederick MDFrederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or ? USA 21701 6230 Glen Valley Terrace Unit C Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical and Mental Hygiene. College (1-4or 5+) Flementary/Secondary (0-12) 12 Customer Service Biomedical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellen Jackson Charles Allen Larkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trat 6230 Glen Valley Terrace Unit C Frederick, MD 21701 Edward W. Fawns/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 07/17/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Licensee MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non-small Cell Lung Cauce Metaolatic a months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of) Examine be executed and resulting in death) Last Due to (or as a consequence of) Box 68760. physician s the buria Physician/Medical as ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atten for u in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 des 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy Yes 2 No 1_ spital or Attending Physician: I hours after death.
Ineral Director: After this certificat y filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 W Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 041866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Kanan H. Hudhud, M.D. 46B Thomas Johnson Drive Frederick, MD 21702 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** FONTANA 13:48 PM SANDRA 15 JULY 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE JOHNS HOPKINS HOSPITAL CITY 9. Birthplace (State or Foreign Country) N.T 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2🏞 F NJ 33 148-64-6264 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or items 23a or 28a-f show dical Examiner must be notified at Somers Point 1XYes 2 □ No NJ Atlantic Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 08244 50 Holly Hills Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, th. Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Computers Computer Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank John Fontana Lisa Clarisse Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 50 Holly Hills Drive, Somers Point, NJ 08244 Frank J. Fontana / Father Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Laurel Memorial Crematory 1 ☐ Burial 2 ☐ Cremation 3X Removal from State July 21,2007 Pomona, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 one 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Fulmona Arrest 10 minutes Physician /Medical Due to (or as a considerace of): Examine System Multiple Organ Sequentially list conditions, if a y, ical inglifty list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons uence of Examine certificate be executed Sepsis ig physician and as the burial-tran Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐ Yes 2 No the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵. pe 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tinpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 💢 No ပ္ this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After t Certification: Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Records, P.O. Box 68760, Division or Vital ne Hospital or Attending Pin 24 hours after death. To the I within 2.

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

32. Registrar's Signature 8 Z007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. WOITE

29c. License number

RES -000

St Baltimore

29d. Date signed (Month, Day, Year)

2007

JULY 15

hanelle Fonch		State of Maryland / 1-For State Registrar		ent of Health and Mental H _e ate of Death	ygiene _{Reg.}	No. 200	7 2301
Physici	an/	Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
ledical Exami	iner	CHANELLE	FONCHA		June 28, 20	07	0616 hrs
		4a. Facility Name (if not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 M F	e (In yrs. last birth	hday) If Under 1 Year If Under 24Hrs Months Days Hours Min.		MM/DD/YYYY) 9. Birtl 2003 Cou	nplace (State or MARYLAND ntry)
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
ž	_	MD MONTGOMERY		ER SPRING			1 X Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	try?
with the Maryland ns 23a or 28a-f sho be notified at once.		138200 CASTLE BLVD		20904		U.S.A.	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene, 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,
after d sl", or	by Fι	3 Widowed 4 Divorced or Dates:	No No	1 Yes 2 x No specify:	5	Specify: BL	ACK
hours natur Exani		15. Decedent's Education (Specify only highest grade com-		Decedent's Usual Occupation (Give kind of viduring most of working life. DO NOT use reti		6b. Kind of Business/Ir	
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5	5+)	NONE	7 to 1	NONE	
5-0036 led within 72 tygiene, other than the Medical	Con	17. Father's Name (First, Middle, Last)			(First, Middle, Ma		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be	IGNATIUS FONCHAM			NUKA		
MD 2 d 2 shoul Ith and M n 27 is m numatic	Ĕ	19a. Informant's Name/Relationship (Type, Print) ALICE ASHU/AUNT	5.4	b. Mailing Address (Street and Number or F 109 HUNT FARM COURT			
e, K I and 2 Health item 2		20a. Method of Disposition	20b. Place o	f Disposition (Name of cemetery,		20c. Location - City or	
MOF Pages ent of nt: If		1 Burial 2 Cremation 3 Removal from Sta 4 Donation 5 Other Specify:	110	ory or other place) INGTON NAT L CEME 7/	14/2007	SHITTLAND I	AARVI.AND
Baltimore, MD 21215-00 permit Pages I and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the M.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility J.	B. JENK	INS FUNERAL	. HOME
	0.0	23a. Part I. Enter the disease, or complications that caused	the death Death	7474 LANDOVER ROA			
Physician /Medical		failure. List only one cause on each line.		it enter the mode of dying, such as cardiac o	r respiratory arrest	, snock, or neart	Approximate Interval Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) a. Smoke Inhalatic Due to (or as a conse					
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equence of):				
0	aminer	cause. Enter Underlying Cause (Disease or injury that initiated					
nd uted	ШĬ	events resulting in death) Last Due to (or as a conse	equence of):				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED					
3760, ficate be g physic s the buri	√Me	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		Fetal death 3 Ectopic pregna	upov.	23d. Date of delivery	ay Year
Box 6876 death certificate he attending phy	sician/	past 12 months?	time of death 5		inicy	Month	ay Year
O. Boy t the deatl by the att	Phys	9 Officiowii	- but not resulting	g in the underlying cause given in Part I.	23e Did toba	acco use contribute to t	he cause of death?
P.O ires that I signed b	þ	Company to deal	r out not resulting	girt the dilacitying educe given in Farti.		2 ✓ No 3 Prob	
rds, requir been s	letec				24a. Was an		opsy findings available ompletion of cause of
eco he law ate has	ompleted				autopsy perform 1 Yes 2	ed? death?	
Vital Records, system: The law requir this certificate has been so director, page 2 should	BeC	25. Was case referred to medical examiner?		26.Place of Death (Check			
f Vil	P	1 Yes 2 No Inospital 1 Inpatie				esidence 6 Other	
on of ending Pl ath. r: After he funeral	Certification:	1 Natural 5 Pending Jun 28, 2007	ear) 200. 1 0445	i hrs 28c. Injury at Work?	28d. Describe ho Subject in hou		
Division at or Attending a figure death. The at Director:	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of In	jury - At home, far	rm, street, factory, office building, etc.	28f. Location (Str	eet and Number or Rui	al Route Number, City
Dj spital hours a neral I	Cert		lti-Family Apt	t	13820 Castle Bi	te) vd #101, Silver Spri	ng, MD
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical	Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner and manner stated.		oth occurred at the time, date and place, and overtigation, in my opinion, death occurred a			
F % F 5	M	29b. Signature and title of certifier		29c. License number	1	29d. Date signed (Mor	th, Day, Year)
	į	Muna Brassell, MD		O.C.M.E.		June 29, 2007	
1	ĺ	 Name and address of person who completed cause of dimensional Melissa Brassell, MD Assistant Medical 	, ,	111 Penn Street, Baltimore, MD	21201		
	_	31. Date filed (Month, Day, Year) 32. Registral		1-0-			
Regist		JOL T O COOL	w B	GOVES			
DHMH 17 Rev 1/2	001	OCHE	ORI	ĞÍNAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

gan i onchai		1- For State Registrar	Certifi	cate of De		i wentai n		g. No. 2	007 2301
Physici edical Exam	an/	Decedent's Name (First, Middle,Last)	ovani.			į.	Date of Death Month	Day Year	3. Time of Death 0600 hrs
eulcai Exam	mer	MEGAN F 4a. Facility Name (if not institution, give stre	ONCHAM et and number)	4b. Cit	v. Town. or I	ocation of Death	June 28, 2	4c. County of	
		Laurel Regional Hospital			urel			Prince Ge	
Funeral Director		5. Social Security Number 6. Sex 218-73-4604 1 M	7. Age (In yrs. last b		nths Days	If Under 24Hrs Hours Min			9. Birthplace (State or Foreign MARYLAND Country)
any.	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	vn or Location					10d. Inside City Limits
*	ب	MD MONTGOMERY		ER SPRIN	(G				1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number			Zip Code		10	g. Citizen of Wha	it Country?
the A		138200 CASTLE BLVD			20904			U.S.A	•
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department Health and Mental Hygiers in the "naturyl", or items 23a or 28a-f sho important; If tiem 27 is marked other than "naturyl", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 1	Was Decedent Ever in U.S. Armed Forces? Yes 2 X No			oanic Origin? (Sp Mexican, Puerto		14. Race - White,	American Indian, Black, etc.
s after iral",	by F	or D	s, Give Year ates:	1 Yes				Specify:	BLACK
2 hour "natu	Completed	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)	College (1-4 or 5+)	a. Decedent's Usi during most of		on (Give kind of t DO NOT use reti		16b. Kind of Busi	ness/industry
036 ithin 7 ne. r than ledical	nple	0	January ()	NO	NE			NON	E
5-0 iled w Hygie I other		17. Father's Name (First, Middle, Last)				8.Mother's Name	(First, Middle, M	aiden Sumame)	
21215-0036 uld-be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	IGNATIUS FONCHAM 19a. Informant's Name/Relationship (Type,	Orint \	19h Mailing Addr	DDC /Street	ELSIE		has City as Tayra	, State, Zip Code)
AD 2 shou h and h 27 is n matic	٦	ALICE ASHU/AUNT	Time,					SVILLE, M	
re, land land Healt fitem		20a. Method of Disposition		e of Disposition (I	Name of cem		Date		City or Town, State
Pages nent of ant; I		1 X Burial 2 Cremation 3 R 4 Donation 5 Other Specify:	enioval itolii State		,	CEME. 7	/14/07	SUITLAN	D, MARYLAND
Baltimore, MD permit Pages 1 and 2 sho Department of Health and Important: If item 27 is night or other transmati		21. Signature of Funeral Service Licensee	0/	22. Name a	and Address	of Facility J.	B. JENI	KINS FUN	ERAL HOME
Physician		23a. Part I. Enter the disease, or complication	ons that caused the death. Do					VER, MARY	
. /Medical		failure. List only one cause on each lin	e. oke Inhalation	The circuit and more	ao oi ayiiig, c	3001 00 00/0100 0	, roopiratory arro	ot, oricon, or riodi	Between Onset and Death
taminer		100	o (or as a consequence of):						
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b	o (or as a consequence of):						
•	Examine	cause. Enter Underlying Cause			2011 E				
760, crate be executed physician and the burial - transit	al Exa	events resulting in death) Last Due t	o (or as a consequence of):						
760, icate be exe physician the burial -	edical		ENDED						
876 tificate ng phy as the l		23b. Was decedent pregnant in the	 If yes, outcome of pregnand Live birth 	cy 2 Fetal dea	ath 3	Ectopic pregna	incy	23d. Date of d Month	delivery Day Year
Box 687 e death certific the attending p	sicia	past 12 months? 1 Yes 2 No 9 Unknown 0	Pregnant at time of death	5 Other (S					
ries that the death certificate by the attending signed by the attending to be detached for use as the	Physician/		Unknown ributing to death but not result	ting in the underly	ing cause di	ven in Part I	23e Did to	pacco use contrib	oute to the cause of death?
P.O. es that the igned by	by	•••			ang seess gi	VOI 111 V CIT 11			Probably 4 Unknown
Records, The law require ficate has been si, page 2 should b	Completed						24a. Was a		ere autopsy findings available
eco he law ite has	dmc						autops perform		ior to completion of cause of eath? Yes 2 🛣 No
an: T	BeC	25. Was case referred to medical				of Death (Check			100 2 22 110
of Vital Records, ing Physician: The law required After this certificate has been funeral director, page 2 should	TO E	examiner? 1 ✓ Yes 2 No	i inpatient 2 V EN					Residence 6	Other:
Division of Vital tal or Attending Physician: rs after death. al Director: After this certifed in by the funeral director		27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation	(Month Day Year)	o. Time of Injury 45 hrs	·	y at Work? es 2 ✔ No	28d. Describe h Subject in ho	ow injury occurred ouse fire	d
Divisal or At a safter dal Direct ed in by	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home, (Specify) Multi-Family A		ory, office bu	uilding, etc.		treet and Number ate) Blvd. #101, Silve	r or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the control of the control o	o the best of my knowledge, d	leath occurred at			due to the cause	e(s) and manner a	as stated.
To t To t	Medical	29b. Signature and title of certifier	manner stated.		29c. License				d (Month, Day, Year)
		W. Lua Brando	M		O.C.N			June 29, 200	
7		30. Name and address of person who comp	eted cause of death (Item 23a	1)					
d			ant Médical Examiner	111 Penn	Street, Ba	altimore, MD	21201		
St Regis	tate trar	31. Date filed (Month Day, Year) 8 2007	32. Registrar's Signature	Speak	9				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 5:34PM Physician MYRA LEE FINE JULY 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baitimore Salkmore City Hospital 86 N/A Sina, 8. Date of Birth (Month, Day, Year) 03/25/1927 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F Days Hours 216-20-6274 80 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8340 SCOTTS LEVEL ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 1 □ Yes 2 🕻 No Specify: WHITE 21215-0036 Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than " College (1-4or 5+) SECRETARY ISRAEL BONDS 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be JACK **EPSTEIN** IDA BRILL ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any Injury or other trau 3378 OLD GAMBER ROAD, FINKSBURG, MD SHELLEY ROUCHARD / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State FORBAND CEMETERY 07/17/2007 BALTIMORE, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature i Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🗶 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 Wo death? 1 ☐ Yes 2 **X** No 1⊟ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours a er death uneral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital or within 24 hours and To the Funeral Di completely filled in 29a Certifier 1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of doth (Item 23a) (Type, Print 1 Armur Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 1 JUL Registrar

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Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Pant)

AMIT SURT 7503 SUrratts Ro

31. Date filed (Month, Day, Year)

8 200

32. Registrar's Signature

08

G859 7/18/07 TT State of Maryland / Department of Health and Mental Hygiene Amend 20b, perFh, 1- For State of Waryland 1- Registrar Amend 12, perFH, G869, 7/18/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** : 38P.M. ILLI 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 07/04/1921 Birthplace (State or Foreign Country)
 NY last birthday) **Funeral** Days Months Hours 1**X** M 2□ F 86 119-09-6291 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County items 23a or 28a-f show ner must be notified at 1 Yes 2 No Director PALM BEACH DELRAY BEACH FL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 33484 U.S.A. 264 PIEDMONT F Funeral Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 17 Yes 25 He If Yes, Give Year or Dates: **Unk.** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or it idical Examin WHITE 1 ☐ Yes 🎾 No Baltimore, Maryland 21215-0036 Specify. Specify: <u>\$</u> 3 XWidowed 4 ☐ Divorced er than "nature , the Medical E Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LIMOUSINE CHAUFFER other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 7 is marked of traumatic even FINKEL SAMUEL GRESACK ROSE ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 9243 RED CART COURT - COLUMBIA, MD 21045 JANET DEAN/ DAUGHTER or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ETERNAL LIGHT Department of Important: If it any Injury or o 1 ☑ Burial 2 □ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) BOYNTON BEACH, FL 07/19/2007 MEMORIAL PARK
22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. - PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5 minute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physlcian: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy 4□Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No မ this 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural
2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kida 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 3:15am **Physician** 2007 Ruth M. Gallagher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Middle River Ivy Hall Nursing Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Month, Day, Year)
Aug. 04, 1914 **Funeral** Months Days Hours Min Maryland 1 ☐ M 25 F 215-42-9515 92 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23a or 28a-f ehov any injury or other traumatic event, it a Medical Exam are must be notified at 1 ☐ Yes 2 No Baltimore Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 USA 103 Center Place Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Frederick Louis Hammann ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1101 Middleway Road Balto. MD 21220 Maureen Plutschak /daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Gardens of Faith 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/16/07 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signatury Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** e0.0 ermar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed burial-transit P.O. Box 68760, 63 ettending physicien and Due to (or as a consequence of): Physician/Medical sete hes been signed by the ettending phys page 2 should be deteched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate hes autopsy performed 2 PNn 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury To the Funeral Director, Afr To the Funeral Director, Afr 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of/certifier 29c. License number 0 30. Name and ad of person who completed cause of death (Item 23a) (Type, Print) 6

DHMH 17 Rev 1/2001

State Registrar

Day, Year)

31. Date filed (Monti

3 Registrar's Signature

07-05417 Timothy Greaney Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 23021

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Physician/ ledical Examiner	1. Decedent's Name Timoth	e (First, Middle,Last)	Greane	Y					Date of Dea Month July 15, 2	Day 007	Year	3. Time of Death 0638 hrs
		f not institution, give st Adventist Hospit				. City, Town, o Takoma P						
Funeral Director	5. Social Security N 065-59-2	2079	7. Age	(In yrs. last bi	rthday) Yrs.	If Under 1 Ye Months Da		Min.		th (MM/DD/Y) 5/1961	Foreig	thplace (State or gn puntry) NY
nd show any. Ice.	Usual Residence of 10a. State MD	f Decedent 10b. County Montgome		10c. City, Tow		r Spri	ng		101	·		10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Nu	mber Cameron Hi	11 Court			10f. Zip Code 20	910		i i	10g. Citizen o	USZ	A
ter death wil	11. Marital Status 1 X Never Marri 3 Widowed	ed 2 Married 4 Divorced If	Ever in U.S.	If Yes	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No specify:					White, etc.	rican Indian, Black, : White	
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More Pages I lent of H int: If it	4 Donation 5	Cremation 3 X Other Specify:			rection		tery	Ju1y	Date 7 19,2		•	Island, NY
	- L).c	uneral Service License	? Maris	hall	F	ame and Address	Ł FST	evens Ave	Fune nue,	ral Hol Baltim	me In ore,	MD 21230
Physician Medical xaminer	failure. List o Immediate Cause or condition result	nly one cause on each (Final disease a	Verapanil : Verapanil :	intoxicat								Between Onset and Death
red Insit	Sequentially list c if any, leading to i cause. Enter Und (Disease or injury events resulting in	mmediate Du leriying Cause that initiated c	ue to (or as a cons								-8	
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit hysician/Medical Fx	23b. Was deceder past 12 month	nt pregnant in the	AMENDED 7, 28 23c. If yes, outco 1 Live birth 4 Pregnant a g Unknown	Ba-f, per me of pregnan t time of death	2 Fe		07 TT	ic pregnar	ncy		ate of delive	ery Day Year
P.O. Bees that the designed by the be detached for the bedeached for the bedeached for the physical for the	3	nificant conditions	contributing to dea	th but not resu	Iting in the u	inderlying caus	se given in P	art I.		res 2 No	o 3 P	to the cause of death? robably 4 Unknown
Division of Vital Records, P.O. Box 68. It all or Attending Physician: The law requires that the death certificate and the formal perfector, page 2 should be detached for use as lead in by the funeral director, page 2 should be detached for use as indification. To Bo Commisted by Webveririan									pe	as an topsy rformed? s 2 No	24b. Were prior to death	
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Division o spital or Attending hours after death or neral Director: After filled in by the fune	2 Accident 3 X Suicide 4 Homicide	Investigatio 6 Could not be determined	28e. Place of I	njury - At home	e, farm, stre	et, factory, offi		etc.	or Tow	State)		Rural Route Number, City coma Pakr, MD
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		Certifying Physicia Medical Examiner:	n: To the best of r On the basis of ex and manner stated	amination and	death occur or investiga	rred at the time	e, date and p	olace, and occurred a	due to the c t the time, d	ate and place,	, and due to	the cause(s)
F w i w i o	29b. Signature at		X a =	n	0		cense numbe OC .C.M.E.				te signed (i 6, 2007	Month, Day, Year)
Ø		dress of person who com. King, Jr., MD.		death (Item 23 Medical Ex		111 Penn	Street, B	altimore	e, MD 212	201		
Star Registra	e 31. Date filed (Mo	JUL 1 8 200	32 Segisti	ar's Signature	600	all of						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Merrell Lee Grafton July 2007 3:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral** 1 XM 2 ☐ F 164-16-2143 Director 86 4, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 900 C Martell Court USA 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify Specify: δ 3 Widowed 4 Divorced WII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within hand Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public Education 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merrell John Grafton ဥ Bessie Lee Bailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tra 900 C Martell Court, Bel Air, Maryland 21014 Sposition (Name of Date 20c. Location - City or Town. State Dorothy L. Grafton / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7-17-07 Deer Creek UMC Cem Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ECTRO MECHANICAL 1SSOCIATION Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine SUSTEMIL burial-trar (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ho Month Vear Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō 28a. Date of Injury (Month, Day Year) Hospital or Attending P 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f To the and manner stated 3 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRWE, SMIE 2/22B BELAIR, MD 21614 DANUSHA SIRITARA

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month July Physician Theresa J. Gianforte /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Arnold FutureCare - Chesapeake If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□ M 2√2 F Yrs. **Director** Feb. 15, 1962 Maryland 216-90-7665 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show rthsn "natural", or items 23a or 28a-f shov the Modical Examinar must be nutified at 1 Yes 2XNo Severn Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21144 Funeral 8134 Windmill Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned 1 Yes 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) marked other than Healthcare Registered Nurse permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any Injury or other traumatic event, 2062s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Audrey McDowell Charles Joseph Gianforte, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8134 Windmill Ct. Severn, MD 21144 Audrey Gianforte / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. Pk. 20a. Method of Disposition 20c. Location - City or Town, State 1 2 Burial 2 Cremation 3 Removal from State Elkridge, MD 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Kirkley-Ruddick Functal Home P. A.

421 Crain Hwy. S.E. Glen Burnie, MD 21061 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on a cluse on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death) Heute Nry scardial Infantion
Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner use as the burial-transi attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Resistant Staphyloica No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy Steep certificate Obstructure 1 Yes 25 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 45 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
2 Accident 1 Tes 2 🗌 No in by the 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funeral I 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cai Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 18, 2007 30. Name and address of passor who completed cause of death (Item 23a) (Type, Print) Highway Suite 204, Millersville, mg 21108 Veterons 8601 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN THEM 19b per H C869 7/19/10 VS
State of Maryland / Department of Health and Mental Hygiene

Registrar

31. Date filed (Month, Day, Year)

2007

Regues

07-05397 Donald Harris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate	of Deati	h		Reg	2. U U	1 2002		
Physici dical Exami	an/	Decedent's Name (First, Middle,Last) Donald Jar	Date of Death	n Day Year	3. Time of Death 1145 hrs						
		4a. Facility Name (if not institution, give street and number) 7934 Naas Road	4c. County of Death Wicomico								
Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$) If Under		er 24Hrs. Min.	8. Date of Birth	irth(MM/DD/YYYYY) 9. Birthplace (State or Foreign CountryMaryland				
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene t: If item 27 is marked other than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomico 10e. Street and Number 7934 Naas Road 11. Marital Status 1 Never Married 2 Xmarried 12. Was Decedent Evarmed Forces?	oc. City, Town or Lo Salisbu ver in U.S. 13. No 1 leted) 16a. Decedering T	ocation 1ry 10f. Zip 2 Was Decede If Yes, specif Yes 2 dent's Usual g most of wor ruck D	nt of Hispanic Orig y Cuban, Mexican X No specify: Occupation (Give king life. DO NOT river 18.Mother	kind of wase retired by the Name of Rondon Roll Roll Roll Roll Roll Roll Roll Ro	ecify Yes or No-Rican, etc.) ork done ed) (First, Middle, Mthy Boyoural Route Number	g. Citizen of What Cou U.S.A. 14. Race - Amer White, etc. Specify: White in the country of the	A. - American Indian, Black, e, etc. White siness/Industry ucking n, State, Zip Code)		
Baltimore, MI permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Locales	Bayview 22	crema Crema 2. Name and	tory Address of Facility	y Go	B/2007 nce Funday Balt	eral Servic	e, Maryland		
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Stab Wounds of Torso Due to (or as a consequence of):							Approximate Interval Between Onset and Death		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at tin 9 Unknown	2	Fetal death Other (Spec		c pregnar	псу	23d. Date of deliver Month	y Day Year		
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Division pital or Attendii ours after death. eral Director: A	Certificati	2 Accident Investigation 3 Suicide 6 Could not be determined Vermined Vermined Specify) Other (specify) Other (specify) 2 Accident Investigation 1 Jul 14, 2007 0734 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State) 7934 Naas Road, Salisbury, March 1 Provided Number or Town, State) 7934 Naas Road, Salisbury, March 1 Provided Number or Town, State) 7934 Naas Road, Salisbury, March 1 Provided Number or Town, State)						ate)	ural Route Number, City		
To the Hospital within 24 hours To the Funeral completely filled	edical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinant manner stated.									
	ğ	29b. Signature and title of certifier Dance Woncert, Mrd		290				29d. Date signed (Mo July 15, 2007	gned (Month, Day, Year)		
13		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	Sall Ja		-					

DHIMH 17 Rev 1/2001

DUME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month July 13, 2007 Herbert Russell Hoopes /Medical 2:40 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Broadmead Retirement Cockeysville Baltimore Birthplace (State or Foreign Country) If Und 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 MM 2□ F 213-38-5140 **Director** Maryland Jan. 15. 1910 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e 13801 York Road 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3X Widowed 4 ☐ Divorced "netural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nt any injury or other traumatic event, It. Mente 2008. Elementary/Secondary (0-12) College (1-4or 5+) 4 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Herbert (nmn) Hoopes Annie Jean Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Hoopes / Daughter in law 1946 Grafton Shop Rd., Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7-14-07 * 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Sen 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician disease or condition resulting in death) 00 /Medical Due ty (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? Records. 2 to 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 A No 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this f Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 D atural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Pcertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 JULY **Physician** Margaret Inez Harlow 17, 3:40 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 74 213-28-0350 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at 1 ☐ Yes 2☐ No Directo Maryland | Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code th and Mental Hygiene. ?7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I 5450 Jim Pickett Road USA 21784 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Carlton Downs Lucy Cornelia Jenkins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Item 27 Is r or other tra Terry A. Harlow/son 2300 Lodge Forest Dr. Baltimore, MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Manorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or 7/21/2007 Eldersburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Haight Funeral Home & Chapel,
P.O. Box 195 Sykesville, MD 2 Dawas (410-795-1400)21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Schama Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a. Was an s certificate has b lirector, page 2 s autopsy performed? To the Hospital or Attending Physician: ours after death.

Ieral Director: After this certificatilled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Watural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of confifier address of person who completed cause of death (Item 23a) (Type, Print) wo

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 15, 11:45 A M Ju₁y 2007 George E. Hunt, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rosedale 7930 32nd St. If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 X M 2 □ F 78 Feb. 14, 1929 New Orleans Director 103-22-7030 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Rosedale Marvland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 21237 7930 32nd St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give 19 Year or Dates: 1 ☐ Never Married 2 👿 Married 'natural", or 1 ☑ Yes 2 ☐ No Specify by Specify. 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other than Elementary/Secondary (0-12) Hygiene. Mechanical Engineer Aircraft permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ruth Moore George E. Hunt, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7930 32nd St., Rosedale, Maryland 21237 Kathleen Hunt (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park 07/19/2007 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical NOR OF URNOWN Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequer Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ **2**□No 3 Probably 4 □Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 55 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural
Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide Transparentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Box 68760 certificate be P.O. Division or Vital Records,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certific stely filled in by the funeral director, To the Hospital within 24 hours a To the Funeral D

State Registrar

Medical

31. Date filed (Month, Day, Year)

29c. License number

ORIGINAL

29d. Date signed (Month, Day, Year) 16.2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Amend Item 2 State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:41 AM Hilda M Hughes 2001 /Medical 4c. County of Death Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner useda Haltimore If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 □ F 213 03 8881 February 9 1920 Director Chio Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 □No Maryland | Baltimore Director Baltimore County 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 7007 1/2 Beech Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√√No Baltimore, Maryland 21215-0036 þ Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 shou d be filed within and Mental Hygiene. Elementary/Secondary (0-12) is marked other than College (1-4or 5+) NATeacher **Education** injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Unknown Charles Eszes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arlene Hughes 6911 Linden Avenue Baltimore, Maryland 21206 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition pe mit. Pages 1
Debartment of H
Im ortant: If itel
an, injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. July 11 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Lassahn Funeral Home Inc. re of Funeral Service Lice 7401 Belair Road Baltimore, Maryland 21236 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory alrest, List only one cause in each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical to (or as a consequence of): cardiovascular disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit Pulmonary Embolism resulting in death) Last e to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1♥ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? es 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes this 27. Manner of Death 1 ☑ Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation neral Director: A filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061662 30. Name address of person who completed cause of death (item 23a) (Type, Print) 9000 Franklin Square Hansen rive Year) 32. Registrar's Signature 31. Date filed (Month, Day, State 2007 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State o	f Marylan		artment o <i>tificate d</i>		d Mental H	ygiene Reg. No. 20	07	23030	
	Physici									Date of Death 3. Time Month July 16, 2007 Year 12:0			
)	/Medic Examin	1.0	4a. Facility Name (If not institution, g Heart Homes	Name (If not institution, give street and number) 4b. City, Town, or Location of Lutherville						4c. County of Death Baltimore			
	Funeral Director		5. Social Security Number 216-01-9511	5. Sex 1	7. Age (In yrs. 95	last birthday) Yrs.	If Under 1 You Months Da		Nonth, E	T, 1911	9. Birthpl Goun Ma	lace (State or Foreign try) ryland	
DESILLIMOYE, IMBRYIBING ZIZI3-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	D	or	Usual Residence of Decedent 10a. State 10b. County Maryland Balt	imore		y, Town or Lo					11	0d. Inside City Limits 1 □ Yes 2 □ No	
	with the N 3a or 28a-	Funeral Director	10e. Street and Number 10f. Zip Code 21093					10g. Citizen of V	What Coun	try?			
	urs after death al", or Items 2 :xaminer mus	by Funera	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Fo	2 ☑No ve	1	Was Decedent f Yes, specify 0 1 ☐ Yes 2 🔀		? (Specify Yes or Nuerto Rican, etc.)	lo- 14. Rac Blac Specify	ce - America ck, White, o		
	within 72 hou ene. than "nature he Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	1-4or 5+)	(Give life. l	dent's Usual Ockind of work do NOT use re	ecupation one during most of tired)	f working	16b. Kind of Bi		lustry	
	ld be filed lental Hygi ked other ic event. ti	To Be Co	17. Father's Name (First, Middle, La Edward F. Kerr				<u></u>	18. Mother's Edit	Name (First, Midd	le, Maiden Surnan			
Mary	und 2 shou alth and M 27 is mar er traumat		19a Informant's Name/Relationship Garland E. Kerr	SON		19b. Mailir 320	ng Address <i>(St</i> i 4 Taylo	eet and Number of P	or Rural Route Num Parkville	nber, City or Town, Marylar	State, Zip nd 2	Code) 1234	
Dallinore, permit. Pages 1 ar Department of Hea	permit. Pages 1 a Department of Hes Important: If item any Injury or othe	20a. Method of Disposition 1 Neurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gard. 07/20/0 21. Signature of Funeral States License 22b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gard. 07/20/0 22. Name and Address of Facility Ruck Towso								07 Timo	on Funeral Home, Inc.		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician / Medical Examiner Due to (+ as a consequence of): Sequentially list conditions.									Approximate Interval Between Onset and Death				
8/00,	cate be executed we physician and into burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									non m Jears	
O. Box oc	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown								ate of deliver	ery Day Year	
as, F.	requires that the een signed by the	by	Tartin. Other significant conditions continuous to death but not resulting in the underlying dadde given in 7 art i.							cco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
Or VITAI MEC Physician: The law	2 S S	Completed						autopsy performed?			prior to cor death?		
	ding I. After fune	ation: To Be	examiner? 1 Yes 2 Wo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp.							rred	,		
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rot City or Town, State)										
	thin 24 hor thin 24 hor the Fune	Medical		xaminer: On the b			vestigation, in		date and place, and due to the cause(s) and manner as s ion, death occurred at the time, date and place, and due to umber 29d. Date signed (Month,			o the cause(s)	
	F 3 F 30		M Both	2 Phl	, M	n 22a\ /T·mc				_			
	5 Sta	ate -	30. Name and address of person w W.A.R. Ley 31. Date filed (Month, Day, Year)		se of death (Iter	B M (ature	C 6	7011	V. Chan	les 51	+ Ba	2007 ltj.nd200	
	Registr		1111 1 0	2007	5.5	H /	hast I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1655 P M 10 2007 Harriet G. Kirchner Ju₁y 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Upper Chesapeake Med. Ctr. Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 1 □ M 🗷 □ F 82 PA 208-16-5524 May 14, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes X ☐ No MD Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 608 L Churchill Road 21014 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2x No White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Gladey Helen Glace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harry Kirchner/Husband 608 L Churchill Road, Bel Air, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 7/13/2007 Bayview Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Tuneral Service Licenses 610 W. Mac Phail Rd., Bel Air, Md Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final infarction MIDCARdia TWO days disease or condition resulting in death) Due to (or as a consequence of): CARdiovascular Atherosclelotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list and average) Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy 2 1 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔀 Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 🗓 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

been signed by a within 24 hours a

Examine

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

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Completed

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death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event the ""...

Physician

/Medical

Examiner

Physician/Medical Completed by Be မ Certification: Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Avenue

29b. Signature and title of certifier

d35522

29d. Date signed (Month, Day, Year)

30. Name and address of person wood completed cause of death (Item 23a) (Type, Print) 2 NORTH IL

BEL AIR MARYLAND

State Registrar

W D

			1 - For State Registrar		of Marylar	-	artmer rtificat					Reg. No.	07	23032	
	Physic	ian	Decedent's Name (First, Midd Vinginia	fle, Last)	Love						2. Date of De	16, Day	7 Year	3. Time of Death	
40	/Medi		Virginia 4a. Facility Name (If not institution)	on give street and nu	Lew		4b City	Town or	Location	of Death	July		ty of Death	10:45 P ^M	
	Exami	ner	Brightwood Lutherville									Baltimore			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th v Year)	9. Birth	place (State or Foreign intry)	
331	Director		212-22-7871	1 M 2 F	82	Yrs.	MOTHES	Days	Hours	IVII(I,	8. Date of Bir (Month, Da May 25	, 1925	Ma	rýland	
	and		Usual Residence of Decedent 10a. State 10b. Count	у	10c. Ci	ty, Town or L	ocation							10d. Inside City Limits	
	ith the Marylan or 28a-f ahow	Director		timore		Luthe	rvill				1 ☐ Yes 2 X			1 □ Yes 2XXVo	
	ath with t	ral Dir	10e. Street and Number 1224 Charmuth Road 21093							USA			intry?		
036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f ahow the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 Tes	ve	J.S. 13.	Was Deceif Yes, spe		ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)	Spec	ack, White	ican Indian, , etc. Asian	
), 45 PM Baltimore Maryland 21215-0036	thin 72 hours e. an "naturel", Medical Ext	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed)		(Give	edent's Usu e kind of wo DO NOT u	rk done d se retired	ation du <i>ring</i> mos	t of work	ing	16b. Kind of		ndustry	
2	be filed within tal Hygiene. Id other than event, the Me	Con	14			Se	ecreta	ary				Cleri			
, vland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be	17. Father's Name (First, Middle Bock Hand	Mon					18. Mothe	or's Name	Leong	, Maiden Suma	ame)		
P Mar	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relation Beth Hecht /Ni									өr, City or Tow ille, N		ip Code) 1093	
	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic e once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (Place of Disponentery, cre	matory or c	ther plac	<i>ө)</i>		Date 8/2007	20c. Location	,	own, State ryland	
0,45 Baltimo	permit. I Departm Importa any Inju		21. Signature of Funeral Service				2. Name ar			I V CA	ck Tows	on Fund	ral 1 212	Home, Inc.	
16/07	7 7 7	Icai Examiner	23a. Part 1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. Due to	each line.	quence of):		0				rrest.	ecse	Approximate Interval Between Onset and Death	
7/ 0. Box 68	law requires that the death certifics as been signed by the attending pt 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 Live I	tcome of pregna birth 2 Feta nant at time of c	al death 3[⊒Ectopic pi ⊒ Other (sp						ate of deliving	very Day Year	
S. P.	uires that signed b	þ	Part II. Other significant condit	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did t	_	acco use contribute to the cause of death? s 2 \(\sum \) No 3 \(\sum \) Probably 4 \(\sum \) Unknown		
al Recor	The ate ha	e Completed	25. Was case referred to medic								1 Yes	propried? 2X No	prior to co death?	opsy findings available ompletion of cause of	
3	Physicien: r this certific ral director,	To Be	examiner?	Hospital:	Inpatient 2] ER/Outpatie	nt 3 DC	Othe			me 5 Pes	dence 6 🗆 O	ther (Spec	(6)	
\ \ o uo			27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o		28c. Injury Work				how injury occu		(9)	
2 Isivia	el or Attending s atter death. Il Director: Atte	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						-	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
J	To the Hospitel within 24 hours a Yo the Funeral (edical (29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the b I Examiner: On the b and man	e best of my kno easis of examina iner stated.	owledge, deal ation and/or in	th occurred evestigation	at the tim	ne, date an pinion, dea	id place, th occurr	and due to the ed at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)	
	To th To th comp	Me	29b. Signature and title of certific	el RI	210	001	290	License	number 564	٠ع		29d. Date sign	ed (Month)	Day, Year)	
	00		30. Name and address of person	who completed caus	se of death (Iter	m 23a) (Type	Print)	/CT	mat/	Sus	etr 200	2/Brat	Hn M	121204	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year	8 2007	legistrar's Signa	ature	Part HP	ه ۱۳	1/		-00	y cur	1012	0001	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ZOO Year Junt **Physician** 9836AM tran K Levett /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Hospital Doctor's Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2□F Greenville SC 577 38 0937 Yrs. Aug 09 1933 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at washington 1 Yes 2 No **Funeral Director** \mathfrak{M} 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Street USA roote 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black þ 3 Widowed 4 Divorced "naturai" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 27 is marked other than "natu er traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Clerk Computer Governmen 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barnes - Niece HW Washington Dc 20010 permit. Pages 1 and 2 Department of Health Important; If Item 27 any Injury or other tra once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/12/2007 Triangle v9 Duantico National 22. Name and Address of Facility Rope Funeral Home 21. Signature of Funeral Service 2617 Pennsylvania Auc SE wash. Dc 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA Physician CUTE /Medical Due to (or as a consequence of) DISEASE **Examiner** ORONALY Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician a s the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Pulmonary 2 No 3 Probably 4 Unknown 1 🗌 Yes Chronic Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No 24a, Was an autopsy perform Prostate Concer 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No d in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft ie Funeral Di vetely filled in Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0050412 07,05, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nation P. Shanmugan 4307A Ramona Drive, Fairfax, VA. 22030 32 Regietrar's Signature 31. Date filed (Month, Day, Year) State 1 8 2007 JUL

DHMH 17 Rev 1/2001

Registrar

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State Registrar 9650

CUPTA

32. Registrar's Signature

SHALLUNMALA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4onth Year **Physician** 200 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner View medica o. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) al Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 10 M 2 F Months Country) 0054 Director 10 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 LYes 2 No Director Md 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ?7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be re-Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry J.K. Elementary/Secondarly (0-12) College (1-4or 5+) tonan 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ ma 47 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIR Health em 27 I 300 auth malone slas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Linera Tome 23a. Part . Enter the sivease, or complications that caused the death. Do not enter the mive of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate C use (Final disease or condition resulting in death) **Physician** ATHEROSCUEROTIC CAUDIOVASCULAR UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thaknown MELLITUS Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION page 2 s autopsy performed? Yes 25 No 2 No MASS 1□ Yes 1 ☐ Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending 1 Natural M 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 051571 18. 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANICO MO 21201 10 HOPKINS PLAZA. BALTIMORE,

Registrar

State

31. Date filed (Month, Day, Year)

JUL

32. Registrar's Signature

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				partment of Health and Mertificate of Death		jiene leg. No. 0 0 7	23036						
I	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Yeer	3, Time of Death						
	/Medic		Edward T. McNulty		Ju1y_		6:35 P. M						
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Aru	ndo1						
	Funeral		1702 Pleasantville Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	8. Date of Birth									
ı	Director		313 32 2610 1₺M 2□F 75 Yrs	(Month, Day June 1	8. Date of Birth (Month, Day, Year) June 1, 1932 9. Birthplace (State or Fore) Country) Maryland								
5-0036 72 hours after death with the Maryland	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Lastin									
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	28e-	Directo	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Coun	trv?						
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Baitimore, mar	d 2 st th and 17 Is n treun			ailing Address <i>(Street and Number or Rura</i> 2 Pleasentville Driv									
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alt	permit. Pages 1 and 2 should be Department of Health and Mente Importent: If item 271s marked any injury or other treumatic evente.		21. Signature of Funeral Service Ligengee		-	eral Service							
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מ כ	e law has b je 2 si	mpie	NEUROGENIC BLADDER		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause death?								
			CHRONIC PAIN		1□ Yes	No 1 ☐ Yes	2□ No						
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Ž	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
ב ב	pritel ours a erel C		29a. Certifier 12 Certifying Physician: To the best of my knowledge, de	ath conversed at the time data and allow									
:	I to the hospitel or Attending Physicien: within 24 hours after death. To the Funarel Director; After this certifica completely filled in by the funeral director,	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, d	ause(s) and manner as sta ate and place, and due to	the cause(s)						
:	To th comp	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month, D	lay, Year)						
			I pheliard ZI MD	D00025	19 2	July 17 :	2007						
	9		30. Name and address of person who completed cause of death (Item 23a) (Typ	_ (1	(1.2	ue Un						
	() Sta	•	31. Date filed (Month, Day, Year) 32. Registrar's Signature	E (RAIN IOWE	KS G	SUEN BUR	U16, FIDE						
	Registra		JUL 1 8 2007	alis									

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar		Certifica	ate of	Death		7.0	Reg.	No.	w 1	
Physician/	1. Decedent's Name (First, Mid	dle,Last)					2. Date Mont	of Death		3	Time of Death
Medical Examine	VEEDA	MERRITT		T 40	·			^h 9, 2007			2044 hrs
	4a. Facility Name (if not institut Johns Hopkins Hosp			41	o. City, Town, or L Baltimore	ocation of	f Death		4c. County of E		
Funeral	5. Social Security Number	6. Sex 7. Age (In yrs. last birt	hday)	If Under 1 Year Months Days		Min. 8. Dat	te of Birth(MM/DD/YYYY) 9		
Director	220-90-6737	1 M 2 X F	46	Yrs.	Months Days	Hours		9/30/	1964	Coun	MARYLAND
<u>*</u>	Usual Residence of Decedent 10a. State 10b. Count	y Inc	c. City, Town	or Locatio	n					1 1	0d. Inside City Limits
# A d			•								XX Yes 2 No
uylane sa-f sh	MARYLAND 10e. Street and Number	N/A	BAL	TIMOI I	10f. Zip Code			10g.	Citizen of What		
ith the Maryland 23a or 28a-f sh notified at once	1821 DIVISION	Cubern Cubern			2121	7			U.S.A.		
with 1	11. Marital Status	12. Was Decedent Ev	er in U.S.		Decedent of Hisp	anic Origi			14. Race - A		n Indian, Black,
r death with r or items 23; must be not	1 X Never Married 2	Married Armed Forces? 1 Yes 2 X	No	If Ye	s, specify Cuban,	Mexican,	Puerto Rican, e	etc.)	White, e		177
s after rral", on iner	3 Vildowed 4L	livorced If Yes, Give Year or Dates:			Yes 2 XX No				эреспу.	BLAC	
OO36 within 72 hour giene. her than "natu Medical Exan	15. Decedent's Education (Sp Elementary/Secondary (0-12	Decify only highest grade complete: College (1-4 or 5+)			s Usual Occupations of working life.			e 1	6b. Kind of Busin	ness/ind	ustry
36 hin 72 than than	unknown	Gollege (1-4 of 51)		PAINT	סקי				HOME I	MDDC	NATMENT.
5-0C ed will tygien other	17. Father's Name (First, Middl	le, Last)		LUIIVI		8.Mother's	s Name (First, M	liddle, Mai		TI ICC	, A TE-111 (T
121 I be fill be fill urked vent,							LIAN GU				-·
D 21 Should Mel ond Mel 7 is ma				_	Address (Street						
and 2 ealth 2 tem 27 traum	Lillian G. Jo 20a. Method of Disposition	hnson/Mother			Division On (Name of cerr		, Balti Date		, Maryla 20c. Location - Ci		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Finneral Director		on 3 Removal from State		ory or othe			07.10.6	, ,	T 7 1/2 D 01 11		MADMI AND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4 Donation 5 Other 21. Signature of Fund Serving	Specify:	MT Z		EMETERY me and Address LIAM C	of Facility	07-19-0				MARYLAND
Baltin permit. I Departm Importa injury o	///	DURINU			LLIAM C : 206 W NO:			YTIV	FUNERAL	HOM	E P.A.
Physician	23a. Part I. Enter the disease, failure. List only one caus	or complications that caused the	e death. Do no	t enter the	mode of dying,	such as ca	rdiac or respira	tory arrest	, shock, or heart		Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final diseas	se a <u>Liver cirrho</u>									Death
	or condition resulting in death)	200 10 (01 45 4 00112040	ience of):								
يِّة	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequ	ience of):								
ted Insit	cause. Enter Underlying Caus (Disease or injury that initiated	C.=	ence of):								
nuted nd ransit		d									
760, icate be executed physician and the burial - transit	X UNPENDED	AMENDED #23a,27,per	ME.g874.	12/13	3/07 TT						_
760, if cate be physical the burn	IF FEMALE: 23b, Was decedent pregnant in	23c. If yes, outcome	of pregnancy		death 3	Fata-ia			23d. Date of de		Vees
Sox 68' leath certificate a strending for use as use use as use use as use use as use use use use use use use use use us		Live birth 4 Pregnant at time	ne of death 5		er (Specify)	Ectopic	pregnancy		Month .	Day	/ Year
by the attending the for use as Physician	1 Yes 2 No 9 🗸 U	nknown g Unknown			. (
P.O.		litions contributing to death b	ut not resulting	g in the un	derlying cause gi	ven in Par		e. Did toba Yes		1	e cause of death?
lS, F quires en sign								a. Was an			osy findings available
Records, The law requires, freate has been significate has been significate has been significate has been significated.								autopsy	pric		npletion of cause of
Re(,					15 1 7		Yes 2		Yes	2 No
lital sician is certificated	examiner?	Hospital:	2 ✔ ER/O	utpatient	10	Other	Nursing Home		esidence 6	Other:	
of V g Phys frer this neral di	27 Mannas of Dooth	28a. Date of Injury	28b.	Time of Inj		y at Work?			v injury occurred		
lon tendim eath or: A the fu	1 X Natural 5 Pe	(Month, Day, Year anding vestigation	,		1 Y	es 2	No				
Division of Vital Records, P.O. spital or Attending Physician: The law requires that the tours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P.	3 Suicide 6 Co	uld not be 28e. Place of Injur	y - At home, fa	rm, street	factory, office bu	uilding, etc		cation (Stre		or Rura	Route Number, City
Dispital Dispital Collection	4 Homicide de	termined (Specify)					- 10				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Be Completed by Physician/Medical Es	29a. Certifier 1 Certifying one) 2 Medical Ex	Physician: To the best of my k caminer: On the basis of examin	_								
To T	29b. Signature and title of certi	and manner stated.			29c. License		CME	2	9d. Date signed	(Month	Day, Year)
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7		on who completed ause of dea			44 P 2:	-1.5.		04001			
	Theodore M. King, J	- 3	Signature	iner 1	11 Penn Stre	eet, Bali	umore, MD	∠1201	_		
State Registra		8 2007 32. Recordar's	w K	do	ack!						
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		9	Decedent's Name (First, Middle, La.	st)							2. Date of D	eath		3. Time of Death	_
	Physicia /Medic		Irvin Howard Ment	zer, Jr.							July 1		ay Year 2007	7:14 A. ^M	
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City	, Town, or	Location	of Death		4	c. County of Death	1	
			Carroll Hospice,					mins		r 24 Hrs.	100 100		Carroll	10	_
	Funeral		5. Social Security Number 6. S	Sex 7.Ag XLXM 2□F	je (In yrs.	last birthday) 56 ^{Yrs.}	Months		Hours	Min.	8. Date of Bi	f Birth (Day, Year) 9. Birthplace (State or a Country) 12, 1951 Maryland			1
- depth-	Director		219-58-2477 Usual Residence of Decedent			50		1			July 1	21]	raar Indr 7	/Ianu	-
	yland how at		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits	
	e Mar	ctor	Maryland Carroll		j	Manche	ster							XXYes 2 No	
	or 28	Director	10e. Street and Number					p Code				10g. C Un	itizen of What Coi	intry? Ces	
	s 23a nust	eral	2779 Washington W	,	Everie II	5 112		1102	ianania O	rigin? (Cr	acifu Vac or N		America 14. Race - Amer	ican Indian	_
_	item item iner r	Funeral	11. Marital Status 1 ☐ Never Married XXMarried	12. Was Decedent Armed Forces?	10	69-	If Yes, sp	ecify Cuba	an, Mexica	an, Puerto	pecify Yes or N Rican, etc.)	0-	Black, White		
215-0036	be filed within 72 hours after death with the Manyland the Wignen. d althyliene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	if Yes, Give Year or Dates:	19	73	1 🗆 Yes	2CXNo	Specify	<i>/</i> :			Specify: Wh	nite	
5	72 hor	Completed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Us	ual Occup	ation	est of work	kina	16b.	Kind of Business/I	ndustry	Ī
Z	ithin and "In Med	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retired	1)	01 07 77017	ung	_		. •	
7	led w lygier her th		12th			Tr	uck !	Orive		or'e Nam	ie (First, Middle		cansporta	ition	
/land	ould be fi Mental H larked ot latic ever	Be	17. Father's Name (First, Middle, Last, Irvin Howard Ment								Strome		ni Surname)		
Ĕ	12 should be h and Mental 7 is marked of raumatic ev	은	19a. Informant's Name/Relationship (19b. Maili	na Addres	s (Street					or Town, State, Z	ip Code)	_
Ma	nd 2 sallth ar 27 is r trau		Susan A. Mentzer			1	· .	ningt					_	and 21102	
ē,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition		20b. F	Place of Disponentery, cre			i		Date		Location - City or		_
Ē	Page nent c int: If		1 ☐ Burial 2XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specil</i>			tro Cr			1.	July 2007	19,	Cat	onsville	e, Maryland	
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	: E := \$:		23a Rart1 Enter the disease, or constant, or heart failure. List only									arrest,		Approximate Interval Between Onset and Death	
4	Physician		Immediate Cause (Final disease or condition resulting in death)	a. G1;	0510	eston	12	Mu	110	for n	16				
	/Medical Examiner		Toolaning in dousing	Due to (or as	a conseq	uence of):									
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0/20	ate br	Physician/Medical	•	d											
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	the d y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown				,							
, ,	s that ned b	by Pł	Part II. Other significant conditions	-		ulting in the u	inderlying	cause giv	en in Part	:1.	23e. Did	tobacco	use contribute to	the cause of death?	
Records,	en sig	ed k	// 57	ne Kno	wh						1 🗆	Yes	2 No 3 Pro	obably 4 hknown	1
ပ	law ras be	Completed									24a. Wa	s an opsy	24b. Were au	topsy findings available completion of cause of)
<u> </u>	The page	Con									per 1□ Yes	ormed?		2 No	
NI CALL	ician; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				O#5		ce of Dea	th (Check only	one)		T	_
0	Phys this al dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatie 28b. Time of			4 🗆 🗅	lursing H	ome 5 Res		6 Gother (Spec	city) HE 12: (2	_
5	ding h. After funei	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	M	28c. Injur Wor 1 □	k? Yes 2[]No	Zod. Describe	11044 111	ary occurred		
DIVISION	Atten r deat ector by the	ifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of inj			reet, facto	ry, office						ral Route Number,	_
5	tal or s afte ai Dir ed in	Certification:	4 Tromicide	building, ei	ic. (opecii	y/ 					City or To	JWII, JIA			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		nysician: To the best miner: On the basis of and manner st	of examina										
	To the within Fo the comple	Me	29b. Signature and title of certifier	/			2	9c. Licens				29d. D	ate signed (Monti	n, Day, Year)	_
			1 Sowans	Avor	7, "	1.0		D	155	-7-5			7/17	107	
	10		30. Name and address of person who	completed cause of	leath (Iten	n 23a) (Type,	Print)	1	<i>-</i> 1	1 -			1 2		-
	Q .		31. Date filed (Month, Day, Year)	Zm) 55	rar's Signa	auth.	Ca	Ster.	STIE	etl	NESTH	W.	F MIN	1 CII	_
	Sta Registr			2007	5%	de de	with the	0							

31. Date filed (Month, Day, Year)

JUL 1 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JUL Day Year **Physician** DONALD L. MOONEY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Eninsula Salisbury Kogional Medica1 WKOMICO 8. Date of Birth (Month, Day, Yes Birthplace (State or Foreign Country) **Funeral** Year) Days Min. 1 X M 2 □ F ours 72 217-30-2702 SEPT. 1934 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 X No Director MARYLAND | WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 30570 ZION RD. 21801 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ÄYes 2 □ No If Yes, Give Year or Dates: 154-157 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) POLICE OFFICER LAW ENFORCEMENT 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be EDWARD CASTLE GLADYS MAE MOONEY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY P. CARROLL / SON 4686 MOUNTAIN RD., PASADENA, MARYLAND 21122 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JULY 16. 1 Burial 2 □ Cremation 3 □ Removal from State 2007 GLEN HAVEN MEM. PARK 4 ☐ Donation S ☐ Other (Specify) GLEN BURNIE, MARYLAND 21. Sign ture of Funeral Vervice Liver see KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, 0 MD 21061 23a. Part# Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** dung Carre /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): physician a the burial P.O. Box 68760 Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? res 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🕅 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Tyes 2**X**) No 2 ER/Outpatient 3 DOA After this funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death e Hospital or Attending Pl 24 hours after death. e Funeral Director; After the telety filled in by the funera 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

Carroll St. Salisbury MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ston 100 E.
32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland / D	epartment of F Certificate of		R	leg. No.	23040	
6	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) ISADORE Mos KO				2. Date of Dea Month	Day Yes		
	Examin		4a. Facility Name (If not institution, give s CARROLL HOSPITAL	street and number) CENTER	4b. City, Town, o	r Location of Death		4c. County of D CARROL	eath	
· 1	Funeral Director		5. Social Security Number 6. Sex	74 OF E	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 04/08/19	ay, Year) Country)		
	he Maryland Be-f ehow	ector	10a. State 10b. County MD BALTIMO 10e. Street and Number	IRE BALTII	MORE			10g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	3a or 2	i Dir	6718 LAURELWOOD AV	'ENUE	10f. Zip Code 21209			U.S.A.	Country	
980	a within 72 hours after death with the Maryland Jiene. r than "natural", or itema 23a or 28e-f ehow The Madical Evaninar mual ba rizdilled at	by Funeral Director		12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. WHITE	
15-0		Completed	15. Decedent's Edu (Specify only highest grade	e completed)	Decedent's Usual Occup (Give kind of work done life. DO NDT use retire	during most of wor	kıng	16b. Kind of Busine	ss/Industry	
212	e filed within It Hygiene. other than "	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ EL	ECTRONICS E			STEEL		
Maryland 21215-0036	0 0 0 0 0	To Be (17. Father's Name (First, Middle, Last)	MOS	KOWITZ	18. Mother's Nan BESSIE	ne (First, Middle,	Maiden Sumame)	ESLOFSKY	
Mary	d 2 sho th and 7 is mu treum		19a. Informant's Name/Relationship (Ty MARALYN REIFEL - D		Mailing Address (Street O RED TULIP					
Baltimore,	00		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Removal from State WORKMAN	Disposition (Name of Screen plans)	07/1	Date 9/2007	20c. Location - City BALTIMORE		
Balti	permit. Page Department Important: Il any injury o		21. Signature of Funeral Service Licens	relia	22. Name and Addre					
8760,	Physician // Medical Examiner physician and physician and the printi-transit the printing of t	icai Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) S- uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		on): SSION				Interval Between Onset and Death	
.O. Box 68	ne death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	delivery Day Year	
<u>α</u>	n requires that the been signed by should be detact	by	Part II. Other significant conditions cor	ntributing to death but not resulting in	the underlying cause gr	ven in Part I.			e Io the cause of death? Probably 4 Dûnknown	
Vital Records,		Completed					24a. Was autop perfor 1 \(\text{Yes} \)	sy prior		
Vita	Physician: 'this certifica	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1 ⊠ Inpatient 2 ⊟ ER/Ou	patient 3 DOA	nor	th Check only of	n <i>e</i> dence 6 □Other (.	Spacify)	
ion of	ling After une	 -	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. T	ime of 28c. Injury Wo			now injury occurred	, , , , , , , , , , , , , , , , , , ,	
Division	il or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office		28f. Location (S City or Tow		r Rural Route Number.	
	To the Hospital or Atterwithin 24 hours after de To the Funerei Directo completely filled in by the	edical C		sician: To the best of my knowledge ner: On the basis of examination and and manner stated.						
1	To the within 2 To the complex	Me	29b. Signature and title of certifier			8 580	1	29d. Date signed (M		
	60		30. Name and address of person who co	3233 SUPERTON IN F	301 BOWIE!	11D 20711	5	•		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 8 20	32 egistrar's Signature	Coule	• •				

07-05121 Gregory James N	1	S - For State	State of Maryla	and / Dep	artment of ertificate of	Health	and	Menta	i Hyg	iene	g. No.	00	7 230
Physicia		egistrar 1. Decedent's Name (First, M	fiddle,Last)							Date of Deat Month		,	3. Time of Death
Medical Examir	ıer		James Mort					4		July 4, 200	7		1857 hrs
*		4a. Facility Name (if not instit		umber)	4	b. City, Tow Cheverl		cation of	Death		4c. County of Prince G		's
Ì		Prince Georges Ho	6. Sex	7 Age (In vrs	. last birthday)	If Under 1		If Under	24Hrs. [8	3. Date of Birt	h (MM/DD/YYYY	g. Birt	hplace (State or n Washingto
Funeral Director		5. Social Security Number 578-94-0088	1X M 2 F	38	Yrs.	Months	Days	Hours	Min.	06/26	/1969	Foreigi Coi	_n wasningto ^{untry)} DC
Birector	-	Usual Residence of Deceder		30					<u> </u>				
any		10a. State 10b. Cou		10c. Ci	ty, Town or Locati								10d. Inside City Limits
*	۲	D.C.			Wash	ingto	n			1 141	,		1 X Yes 2 No
faryla 28a-f	Director	10e. Street and Number				10f. Zip Co				1	0g. Citizen of Wh		ntry?
eath with the Maryland items 23a or 28a-f show ust be notified at once.		3500 14th S				<u></u>		010	0.10	Was in Na	U.S.		can Indian, Black,
t be n	Funeral	11. Marital Status 1 Never Married 2		ecedent Ever in Forces?	If Y	s Decedent es, specify (of Hispa Cuban, I	anıc Origi Mexican,	n? (Spec Puerto Ri	ify Yes or No can, etc.)		e, etc.	carringan, brack,
or deal	킖		1 Yes Divorced If Yes, Give Y			Yes 2X	No	specify:		•	Specify:	В1	ack
ırs aftı ınral'	þ	15. Decedent's Education	or Dates:) 16a. Deceden	t's Usual Oc	cupatio	n (Give k	ind of wor	rk done	16b. Kind of Bu	isiness/	Industry
72 hou	Completed	Elementary/Secondary (0)-12) College	(1-4 or 5+)	during m	ost of workir	ng lire. L	JO NOT L	ise reurec	ı), , , ,			
036 vithin ene. ar tha	dm	12th			Ta	too A			None (ient Middle	Self- Maiden Surname	-Emp	loyed
15-0 filed w Hygid d other		17. Father's Name (First, Mi Harold A								E. Mor		,	
121 Id be I Mental Marke	To Be	19a. Informant's Name/Reia	•		19b. Mailin	g Address					nber, City or Tov	vn, State	e, Zip Code)
2 shou and N	F	Brenda J. Mo			3500 Washi	14th S ngton	Stre D.	et, C. 2	N.W. 0010				
e, N L and S Health item S		20a. Method of Disposition			b. Place of Dispos crematory or ot	sition (Name	of cem	etery,		Date	20c. Location Baltim	•	
nor of int. If		1 X Burial 2 Crem 4 Donation 5 Oth		from State	Mount Zic		ete	ry	07-1	3-2007	7	OIC	, haryranc
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Se	ervice Licensee	2									lome, Inc.
E Pe C		Manda	C. R	acon,									D.C. 20010 Approximate Interv
Physician		23a. Part I. Enter the diseas failure. List only one of	cause on each line.			the mode of	aying, s	such as Ca	ardiac or i	:	rest, snook, or m	, and	Between Onset and Death
'Medical aminer		Immediate Cause (Final dis or condition resulting in dea	sease a. Multiple (
`			h	s a consequent	se or).				•				
	Jer	Sequentially list conditions if any, leading to immediate	e Due to (or a	s a consequenc	ce of):								
	Examine	(Disease or injury that initia	ated C.	s a consequenc	ce of):								
uted id ansit		events resulting in death)	d										
e executed zian and rial - transit	lica	UNPENDED	X AMENDE	erME.g86	9,7/18/07	Т					1100-000		
Box 68760, a death criffcate be the atter ding physic ed for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnar	23c. If ye	es, outcome of	oregnancy		2	Estania	c pregnar) CV	23d. Date of Month	of delive	ry Day Year
68 criff di g	ian	past 12 months?	, <u></u>	re birth egnant at time o		etal death other (Speci	3 L	Ectopii	c pregnar	icy			,
30x death	ysic	1 Yes 2 No 9		known									11 - 1 - 1 - 1 - 1
tecords, P.O. Box 68760, he law requires that the death carificate be are has been signed by the atter ding physici age 2 should be detached for use es the buri	Y Ph	Part II. Other significant of	conditions contributing	g to death but r	not resulting in the	underlying	cause g	iven in Pa	art I.				o the cause of death?
ires the signe	d by	<u> </u>								24a. Wa			autopsy findings availat
ords w requests been should	ompleted									aut	opsy formed?		completion of cause o
Recc The laver ate ha	E O									1 🗸 Yes		1 🗸	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the Director After this certificate has been signed by led in by the funeral director, page 2 should be detach	Be C	25. Was case referred to n examiner?	medical Hospital:					of Death Other			Residence 6	Oth	ner:
*hysic rthis	ြို	1 ✓ Yes 2 N	lo		2 ER/Outpatie			ry at Wor		g Home 5 28d. Describ	e how injury occu		
n of ding F	Ë	27. Manner of Death 1 Natural 5	Pending Jul 4	ate of Injury onth, Day,Year) , 2007	1800 hrs			Yes 2 ✓	_ 14		not by police		
SiOl Atten r death ector: by the	cati	2 Accident	Investigation 28e. F	Place of Injury -	At home, farm, str	eet, factory,	office b	ouilding, e	etc.	28f. Location	(Street and Nun	nber or	Rural Route Number, C
Divi	Certification:	3 Suicide 6 4 ✓ Homicide	Could not be	cify) Local S					-	or Town 100 Block D	, State) Division Ave. N	.E., Wa	ashington , Md D
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death crificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte (ding physici completely filled in by the funeral director, page 2 should be detached for use as the buri	cal Ce	29a Certifier	ying Physician: To the al Examiner: On the ba	best of my kno	wledge, death occion and/or investig	urred at the	time, da	ate and p	lace, and ccurred a	due to the ca	use(s) and manr te and place, and	ner as st	tated. the cause(s)
To the within To the comp	Medical	29b. Signature and title of	and mann	er stated.				se numbe	_				Month, Day, Year)
		Whina B	Rassell No	D			O.C.	M.E.			July 5, 20	J07 ———	
_		30. Name and address of Melissa Brassell		cause of death Medical Ex	(Item 23a) aminer 111	Penn St	reet, E	Baltimo	re, MD	21201			
	12.5	01.51.101.11.5		2. Registrar's Si							· · · · · · · · · · · · · · · · · · ·		
Regi	state stra	11	11 1 8 2007	Maria	UK,	mark	_						
DHMH 17 Rev 1/			0016	#	ORIGIN	AL							

07-05385 Kenneth Mathis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland	/ Department of H	lealth and Menta	al Hygiene

	iour mound		1- For State Criticate of Death Registrar	i Wortan riye	Reg.	No.	107 2201
lo d	Physicia lical Exami	ın/	1. Decedent's Name (First, Middle,Last) Kenneth Dewey Mathis		Date of Death Month D	av Year	3. Time of Death 0635 hrs
//eu ∕~″	IICAI EXAIIII		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo		July 14, 200	4c. County of E	
			13 Scott Avenue Glen Burnie			Anne Arur	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 2 16.82.2261 1 Mm 2 F 42 Yrs. If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth(ÎF	o. Birthplace (State or oreign Country) Wash, D
	au à	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
7	*	٥	MD Anne Arundel Glen Burnie	е			1 Yes 2 No
	ith the Maryland 23a or 28a-f show notified at once.	I Director		060		Citizen of What USA	
_	hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hisp. If Yes, specify Cuban, If Yes, specify Cuban, If Yes, Give Year 1 Yes 2 No 1 Y	Mexican, Puerto Ri		14. Race - A White, e	American Indian, Black, etc. White
	ours afi atural' kamine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation	on (Give kind of wor	rk done 1	6b. Kind of Busir	ness/Industry
	77 " →	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 + Diesel Mech)	Autor	notive
	5-0036 fled within Hygiene. I other tha	E O		8.Mother's Name (F	irst, Middle, Ma		110 5 1 4 2
	21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a	Dewey Mathis			ne Jame	
	e, MD 21215 I and 2 should be file Health and Mental Hy item 27 is marked o	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street				
	e, MD I and 2 sho Health and item 27 is	}	Ms. Sabrina Mathis wife 13 Scott Ave 20a. Method of Disposition 20b. Place of Disposition (Name of ceme	e. GIEN	Date 2	20c. Location - C	2 1 U 0 U ity or Town, State
/	= s 4 = a 1		Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Bayview Crematory	ory 7/3	18/07	Balto.	. , MD
1	Baltimore, permit Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee 22. Name and Address of	of Facility S 1 a	ack Fu	neral H	lome, P.A.
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s	Columb :	ia Pika espiratory arrest	MD 2	2 1 0 4 3 Approximate Interval
	/Medical	W	failure. List only one cause on each line. Immediate Cause (Final disease a Narcotic (fentanyl) and cocaine into				Between Onset and Death
	Examiner		or condition resulting in death) Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, leading to immediate b				
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Constitution of the Constitution of the Constitution of the Constitution of the Constitution of the Const				_
	cecuted 1 and - transit	Ě	d.				
	'60, ate be exe oby sician a	Medical	X UNPENDED #23a,27,28a-f penME.g870 8/30/07 TT	Γ			
	876 tificate ng phy as the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	¬	су	23d. Date of de Month	elivery Day Year
	Box 687 death certific the attending of for use as t	Physician	Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown				
	D.O. Box 68: that the death certiff ned by the attending detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	iven in Part I.	23e. Did toba	acco use contribu	ute to the cause of death?
	ords, P.O. w requires that the as been signed by should be detact	d by			1 Yes	2 No 3	Probably 4 Unknown
	ords w requi	olete			24a. Was an autopsy	pri	ere autopsy findings available or to completion of cause of
	Reco	Completed			perform 1 ✓ Yes 2		eth? Yes 2 No
	ital Recicion: The Secrificate Secrificate Irector, page	Be	examiner? Hospital: 1 Inaction 2 ER/Outpatient 3 DOA	of Death (Check or Other, Nursing		esidence 6	Other: Scene
	Division of Vital Records, tall or Attending Physician: The law requirers after death. "I Director: After this certificate has been sited in by the funeral director, page 2 should be	2	1 Ves 2 No		limm/	w injury occurred	
	ion trendin leath. tor: A	atior	1 Natural 5 Pending Pending Fnd 7/14/2007 Fnd 6:30 am	es 2 X No	unk		
	Division pital or Atteur ours after death eral Director:	Certification;	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office but	0.	or Town, Sta	te)	or Rural Route Number, City
	lospita 4 hours uneral		29a. Certifier 4 Contifier Physician To the best of my knowledge, death occurred at the time date				Burnie, MD s stated.
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	death occurred at	the time, date ar	nd place, and due	e to the cause(s)
	F 3 F 3	Me	29b. Signature and title of certifier 29c. License				(Month, Day, Year)
			Maryone The Whell O.C.N	vi.E.		July 15, 200	
-			Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner	altimore, MD 2	1201		
		ate					
	Regis	trar	JUL 1 8 2007 Blegue & Specks				

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

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			State of Maryland / Department of Health and 1 - Registrar Certificate of Death	-	giene Reg. No. 200	7 23043
	Physici		Decedent's Name (First, Middle, Last) William Robert Niederhauser	2. Date of De July		3. Time of Death 1:55 P. M
)	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dec. 480 Kenora Drive Millersyille		4c. County of De	unde1
l	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 6. Sex 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Months Days Hours Mi	lin. (Month, Da	9. Bi 6, 1937 Ca	irthplace (State or Foreign Country) 1ifornia
Marylan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Tollege (1-4or 5+) 5+ 17. Father's Name (First, Middle, Last) Robert Gurwell Niederhauser 19a. Informant's Name/Relationship (Type. Print) Mrs. Urai Niederhauser/Wife 16a. Decedent's Usual Occupation (Give kind of work done during most of wild.) Linguist 18. Mother's N 19b. Mailing Address (Street and Number or Mrs. Urai Niederhauser/Wife) 480 Kenora Dr. Mill	working Name (First, Middle 1 Lillian r Rural Route Numb	Black, When Specify: 16b. Kind of Busines Federal Good, Maiden Surname) Offord Der, City or Town, State	tates nerican Indian, lite, etc. White s/Industry overnment , Zip Code) 8
8/60, Carimore,	Physician /Medical Examiner	dical Examiner		diac or respiratory a		1e, MD 21061 Approximate Interval Between Onset and Death Months Months Months
, P.O. BOX 6	The law requires that the death certificate be experient ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/ Physician/Med		23e. Did	23d. Date of o Month	Day Year
oras	w requires been sign should be	eted by			_	Probably 4 Unknown
Vital Hecords,	slcian: The law certificate has t irector, page 2 s	Completed		pert 1□ Yes	ppsy prior t death 21 No 1 □ Y	autopsy findings available o completion of cause of ? es 2 \sum No
DIVISION OF VIT	ing Phy After this uneral d	Certification: To Be	examiner? 1 Yes 2X No	28d. Describe	one) sidence 6 □Other (S) how injury occurred (Street and Number or own, State)	
วั	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	ledical Cer	29a. Certifier (Check only (Ch			
l	To the I within 2.	Medi	29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)	021	29d. Date signed (Mc	
	Sta Regist	ate rar		50 Gambr	ills, MD 2	1054

Please Type or Print in Black Indelible.Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** JULY 2007 10:05 14. John Harold Nussle Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5, Social Security Number 6. Sex 11 M 2□ F **Funeral** Days Months Hours 12, 1950 Maryland Director 214-58-5731 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 1545 Hollingsworth Road 21.085 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after a nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Assisted Living Elementary/Secondary (0-12) College (1-4or 5+) Facility Facilities Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ William Henry Nussle Pearl Marie Hoxter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frances H. Nussle / Wife 1545 Hollingsworth Road, Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages
Department of Important: If its
any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Grdn 7-19-07 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility MCCOMAS Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complic sions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DECADES disease or condition resulting in death) CURUNARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 dunknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No 24a. Was an autopsy performed? Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fi 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I t 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRINKER.

DAVID A.

31. Date filed (Month, Day, Year)

29c. License number

D51852

M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

+/16/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** KATHERINE M. PERDUE JULY 16, 2007 7:58 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 519 Greenway S.E. Glen Burnie If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 □ M 2 🔀 F Director 214-52-8985 58 MAY 31, 1949 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 21 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 natural", or Items 23a Funeral 519 GREENWAY S.E. UNITED STATES 21061 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14 Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. SALES CLERK RETAIL SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM H. SMITH ESTHER M. SULLIVAN ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7733 Telegraph Rd. Lot 56 Susan Mills / Sister Severn, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 20 Department of HIMPortant: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 □ Donation 5 Other (Specify) Metro Crematory Catonsville, MD 21. Signatur Funeral Service Licenses 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY. GLEN BURNIE, MD 21061 SE 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition mus resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760,7 The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an has e 2 autopsy performed certificate 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 5 ☐ Pending investigation Natural 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day,



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #30, perDVR, g869, 7/18/07 TICertificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 14, July 9:30 P Eula Mae Parrigan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Top of the Hill Manor Harford Street 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F Yrs 226-10-7088 **Director** 84 12, 1922 Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ehow rthen "neturel", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Harford Maryland Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 300 Bynum Ridge Road 21050 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 25 No Specify: Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) 5 Presser Sewing Factory 27 is marked other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eugene Landes Herring Dessie Gertrude Kyger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Knopp / Caregiver 300 Bynum Ridge Road, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of Middletown Methodist 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-19-07 Episcopal Cemetery Freeland, Maryland 21. Signature/of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Fart. Enve the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on elich line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner hethe death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 0.0 detached 9☐ Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has burector, page 2 s Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No Assisted ŏ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ivision Living 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: within 24 hours a
To the Funeral C
completely filled

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Emory J. Linder Top of the Hill Manor, Street, MD

32. Registrar's Signature

State Registrar

cai

31. Date filed (Month, Day, Y

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Franklin Pobletts Milton 9:30p Ju1_v 15 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Sykesville Fairhaven If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours **1**√ M 2 F 220-12-7714 81 MD Director Feb 28 1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at MD Carroll Sykesville 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or odical Examiner must be r 7200 Third Avenue Apt. M411 USA 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 TYYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) liquor/beverage owner/operator of liquor store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lemmel Pobletts Goldie Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave., Sykesville, MD 21784 Mary Pobletts (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 17-17-07 Sykesville, MD 21. Signature of Funeral Service Licensee #ATCHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 augh MO0X64 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ementia ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tra Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 After this certificate 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

(Check only one) 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 8



Stone

Box 6876(P.0. SHIRLEY PETERSON Records, Vital

/Medical Examiner sician and e burial-trans phys. the b as detached director, or Attending nin 24 hours after death the Funeral Director: filled in by completely

Physician

/Medical

Examiner

MD

Director

Funeral

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Be Completed

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Funeral

Director

"natural", or items 23a or 28a-f shov sdical Examiner must be notified at

filed within 72 hours after

es 1 and 2 should be fil of Health and Mental H I Item 27 Is marked otl r other traumatic even

of Health a

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Department of H
Important: If Itel
any Injury or ott

Physician

21215-0036

Maryland

Baltimore,

2007

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JULY

	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf pregni 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	ıl death 3 □Ectopi				-	23d. Date of deliv Month	ery Day	Year
2	Part II. Other significant conditions	contributing to death but not res	ulting in the underlyin	g cause	given in Part I.			se contribute to □ No 3 □ Pro		
combiered.						24a. W au pe 1∐ Ye	topsy rformed?	death?	opsy finding ompletion of	s available cause of
	25. Was case referred to medical examiner?	11			26. Place of De	ath (Check on	y one)			
2	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□	DOA	Other: 4 Nursing I	Home 5□Re	esidence	6 XIOther (Speci	fy) HO	SPICE
	27. Manner of Death 1 Matural 2 ☐ Accident 5 ☐ Pending investigatio	28a. Date of Injury (Month, Day Year) n	28b. Time of Injury M		Injury at Work? 1 □ Yes 2 □ No	28d. Describ	e how injur	y occurred		
Certification.	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, fac y)	tory, off	ice	28f. Location City or	(Street an Town, State	d Number or Rur	al Route N	mber,
	29a. Certifier (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death occurration and/or investigat	ed at the	ne time, date and plac my opinion, death occ	e, and due to t urred at the tin	ne cause(s) ne, date and	and manner as	stated. to the cause	e(s)
	29b. Signature and little of certifier)			ense number		29d. Dat	te signed (Month,	Day, Year,	
	30. Name and address of person who	completed cause of death (Iten	n 23a) (Type, Print)							
	DR. TARIO MAHMO	OD 2300 DULAN	EY VALLEY	RD.	TIMONIUM	i, MD 2	1093			
е	31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	nture	-						
r	JUL 1 8 2	UU/ Doche .	J. Bones	1						

ORIGINAL

Amend Item 8 per fil c873 11/28/07dlab lealth and Mental Hygiene Amend Item 7 per fil 8/78/07/28dlab 04/07/dlab Reg. No. 25, 27, 28a-1 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death **Physician** 1:50 PM chel orma 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give steet and number) Examiner Nursing & If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number Sex 1 M 2 ☐ F **Funeral** Days Months 55 6615 11/02/1951 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once. MD 1 tes 2 No Director timore 10g. Citizen of What Country? 10e. Street and Number 21218 USA tvenue laian Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Maryland 21215-0036 Specify: þ Slac 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) High power done during most of working High power wife done during most of working the power of Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Be 19b. Mailing Address (Street and Num Heathsville, VA 22473 imberland Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State Heathsville 21. Signature of Funeral Service Licensee bervices ile 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspeation erminal **Physician** /Medical Due to (or as a consequence of) NED BY MEDICAL EXAMINER Examiner Serile Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) CERTIFICA Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pł I for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🕱 No 2**X** No funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 N 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ¥Yes Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Magner of Death 28b. Time of 28c. Injury at Work? After t Natural

Accident

Suicide 5 ☐ Pending investigation 1 ☐ Yes 2 🙀 No Multiple falls Unknown M Unknown within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Unknown 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D32158 7/16/07 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Jaw Steet, Shite 407, Bultimy MB 2/201 Pas 821 N. Jyotin 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 12PM **Physician** Snirley Ann Rose July /Medical 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMOY 8. Date of Birth (Month, Day, Year) Feb. 12, 1949 If Under 1 Year If Under 24 Hrs 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F Yrs. 219-50-4357 58 MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Medical Examiner must be notified at Director Baltimore txfxfYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 21216 1814 North Braddish Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1XXNever Married 2 Married "natural", or 1 ☐ Yes XXX No African þ Specify: 3 ☐ Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 desk clerk District Court Department of Health and Mental Hy, Important: If Item 27 is marked other any injury or other traumate. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rueben Rose Mary Lolita Davis ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arleathea Rose / Sister 801 Appleton Street; Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 07/20/2007 4 Donation 5 Dother (Specify) Randallstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service bicenses Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217 23a Part1. Enter the disease accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eass disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Due to (or as a consequence Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No was a... autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To eral Director: After th filled in by the funeral 27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and five of certifier of person who completed cause of death (Item 23a) (Type, Print) CATON AVE, BALTIMORE, MD21721 32. Regionar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stata Registrar	State of Maryla		artment of H			Rag. No.	23051
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	Betty	Scott			2. Date of De Month	Day Year	3. Time of Death 7 4 5 7 M
	Examir Funeral Director		4a. Facility Name (If not institution, give in the control of the	PIKESU	LLE. last birthday) 3 Yrs.	_	Location of Death VICL C If Under 24 Hrs. Hours Min.	=, mi	th 9. Bir	th ORC Thplace (State or Foreign ountry)
	D		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation		0000	2-77	10d. Inside City Limits
	he Many 18a-f sh otified	ector	MD N	/A	Ba	Himone				1 ☐ Yes 2 ☑ No
	th with t	ai Dir	10e. Street and Number	and Road		10f. Zip Code	8051		10g. Citizen of What C	ountry?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "natural", or Itams 23s or 28s-f show other traumetic event, it is Madical Experimet must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		pecify Yes or No o Rican, etc.)	Specify: A	
21215-0	d within 72 h giene. ir than "natu ir e Madical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occups kind of work done of DO NOT use retired	during most of wor)	king	16b. Kind of Business	,
and	2 should be filed withir and Mental Hygiene. Is marked other then aumetic event, It e.M.	To Be C	17. Father's Name (First, Middle, Last)	Robertson,	Sin		18. Mother's Nan		Maiden Surname)	
Maryland	12 should In and Men Is marka	-	19a. Informant's Name/Relationship (Ty)	pe, Print)		/	and Number or Ru	ral Route Numbe	er, City or Town, State,	
	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	lamoval from State	cemetery, crer	sition (Name of matory or other place		Date B	20c. Location - City or	
Baltimore,	permit. Pag Department Importent: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22	Name and Address	is of Facility	se Fun	enal Serv Baltimone	ite, P.A.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the dea	th. Do not ent	er the mode of dying	g, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conse		Brast C	ancer			
2		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					
68760, 6	ificate be executed physician and as the burial-transit	cai Exar	that initiated events resulting in death) Last	Due to (or as a consec	quence of):			-		
	± 00 m	/Medicai	IF FEMALE:	3c. If yes, outcome of pregn	ancy					
.O. Box	the death	Physician/M	23b. Was decedent pregnant in the past 12 mopths? 1 Yes 2 No 9 Unknown	1 Live birth 2 Feta 4 Pregnant at time of 6 9 Unknown	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
ords, P	w requires that been signed b should be det	by	Part II. Other significant conditions con	stributing to death but not res	sulting in the u	nderlying cause give	on in Part I.		obacco use contribute t Yes 2 □ No 3 □ P	
of Vital Records,	(0) 14	Completed				_			an 24b. Were an prior to death?	utopsy findings available completion of cause of
Vita	sician: certific rector,	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐	EP/Outpation	t 3 DOA Cthe	26. Place of Dea			
	fter fter	-	27. Manner of Death 1 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?		dence 6 Other (Spenow injury occurred	iciny)
Division	or Attanding after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of tnjury - At h building, etc. (Speci	ome, farm, stre		∕es 2□No	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
_	To the Hospitel or Attandi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	edical Co	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occu	and due to the rred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
)	To th within To th compl	Me	29b. Signature and title of certifier Notainpunsement).		29c. License	number 5746		29d. Date signed (Mont	th, Day, Year)
	4		30. Name and address of person who con -N.S. Rimapakse, M		m 23a) (Type,					
	Sta Registr		31. Date filed (Month, Day, Year) 1111 1 8 2007	mpleted cause of death (Ite 2835 32. Registrar's SAA	ature	2	1 4 1/4 1/4 1/4		<u> </u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mary	•			lental Hygi	ene	
	~		1 - State Registrar	Cei	rtificate of D	Death		J. No.	23054
	Physici		1. Decedent's Name (First, Middle, Last) Elisa M. Sala				2. Date of Death Month July 15	Day Year	3. Time of Death 5:42 PM
5	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	•	4c. County of Deat	
T			2525 Pot Spring Rd., Apt L50		Timoniu	LIM If Under 24 Hrs.	0 D-4 (D)-11	Baltimo	
- 9	Funeral Director			n yrs. last birthday) 36 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Aug 17,	Year) 1920 Mai	hplace (State or Foreign untry) cyland
	and w		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	tor	MD Baltimore	Timoni					1 □Yes 2 □No
	in the or 28a anotif	irec	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	untry?
	23a cust be	ral	2525 Pot Spring Rd., Apt L50		21093			U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2☐√No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
2-0	72 hou natura lical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	ation Juring most of work	ina 10	6b. Kind of Business/	Industry
$^{M}.$ Maryland 21215-0036	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	1	kind of work done d DO NOT use retired) Emaker)	9	Own hom	ne
nd 2	e filed al Hygi I other vent, t	S B B	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	,	
<u>y</u> laı	ould b Ments narked natic e	2	John DeAngelis	1		Josep		gliava	
.Mar	d2sh thand t7 is m traum		19a. Informant's Name/Relationship (Type. Print) Anthony B. Sala-husband	I	-			City or Town, State, 2 Timonium ,	. ,
2 P	of Heal		20a. Method of Disposition	20b. Place of Dispo		- ;	·	Oc. Location - City or	
5:42 Paltimore,	Page ment c tant: If tury or		Tabliani Carlon (Opcony)	Dulaney \	Jalley	7/19		Timonium,	
Ball	permit Depart Import any in	. 0	21. Signature of Funeral Service Licensee William G		1050 York	Rd., Tou	uson, MD	Funeral H 21204	Home, Inc.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line lime disease or condition resulting in death) Sequentially list conditions,	onsequence of):	er the mode of dying	g, such as cardiac		st,	Approximate Interval Between Onset and Death On Onthic
007 3 8760 ,	certificate be executed ding physician and se as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Unidentifying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a condition of the						
. 15, 2 D. Box (uires that the death certific signed by the attending p d be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome pf pregnant at time past 12 months? 4 ☐ Pregnant at time percent in the past 12 months? 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnancy]Other <i>(specify)</i>			23d. Date of del Month	ivery Day Year
JULY ds, P.(requires tha sen signed I rould be det	by	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause give	n in Part I.		acco use contribute to s 2 ≧ No 3 □ Pr	the cause of death?
SALA JU or Vital Records,	N of S	Completed					24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
"A /ita	s ician; Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				h (Check only one,	`	
SALA or Vit	Physician; this certific	္ရ	1 ☐ Yes 2DNo Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier		4 Li Nursing no		ice 6 Other (Spe	cify)
	ding h. After funer	tion	1. Natural 5 Pending (Month, Day Ye	ear) Injury	Work	rai ? /es 2□No	28d. Describe hov	v injury occurred	
ELISA Division	To the Hospital or Attending Physician: The la Within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury building, etc. (\$\frac{1}{2}\$	- At home, farm, str Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	ospital of hours af ineral D		29a. Certifier 12 Certifying Physician: To the best of m						
	the Ho lin 24 I the Fu	Medical	(Check only 2 Medical Examiner: On the basis of ex and manner stated						
	vith con	Δ	29b. Signature and title of certifier Methy	At, MD	29c. License	5274	29	Monday	July 16th 2007
	51		30. Name and address of person who completed cause of death ERNESTINE WRIGHT, M.D. 2300		Print) VALLEY RO	OAD TIMO	ONIUM, MD	21093	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's		Coast .				
	Registi	ar		- 10 Gal	The state of the s				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 1236 AM Scroggins /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner of Maryland Med. Baltimore University NA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1 ☐ M 2 🙀 F 216-68-2942 Director 7-30-1953 Md. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f show notified at 1 ☑Yes 2 ☐ No Md Baltimore NA Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. ral", or items 23a or Examiner must be r 21223 USA 513 N. Gilmor Street Apt. Completed by Funeral 14. Race - American Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify Black 3 ₩ Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Disabled NA s marked other t umatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ozzie Bell Truesdale Jones, Sr. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important; If Item 27 Is m any injury or other traum once. 513 N. Gilmor St. Apt. 1, Baltimore, Md. 21223 Lavonnya Barnes Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-18-07 Baltimore, Md. Greenmount Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. Fast 21202 la 1101 E. North Ave., Baltimore, Md. 2 anes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cerebral day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last See to for tis a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Year Month Dav in the past 12 months? 5 Other (specify) 2 | No the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2IX No prior to death? 1□ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 npatient P 24 hours after death. • Funeral Director: After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

8

31. Date filed (Month, Day,

Benni

Year)



5.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND FIEM 200, per FH, CS69, 7/18/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician eavett oriber 2007 10:50 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number Baltimure Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | DeC | 14, 45 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 F 5170 Yrs. marylan Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 1 √ es 2 No Funeral Director md. are m 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be r US 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Neyer Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black Specify. Specify: Be Completed by 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ltimare Elementary/Secondary (0-12) College (1-4or 5+) CIH 2-11 organizer MMUNITY 18. Mother's Name (First, Mighile, Maiden Surname) 17. Father's Name (First, Middle, Last). eavern NO ٩ 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Loyola Kasha VInson daughter northway Apt Cto, md, 21219 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signatu e Funeral Servi LLC 22. Name and Address of Facility edHIL Tales Pimarch 1 Betto, md, 21229 Zineral 23a, Part, for Me disease, or complications that caused the drath. Do not enter the more of dying, such as cardiac or respiratory arrest, side k, in heart failure. List only one cause on each line.

Immediate Cause (Final disease) for condition resulting in death)

a. Due trong as consequence of the condition resulting in death) Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Assimition Freumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of): Examiner requires that the death certificate be executed the burial-transit Stroke Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical as attending for use IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Dav 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the truneral director, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient Medical Certification: To 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident hours after death uneral Director: filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D.

State Registrar

DHMH 17 Rev 1/2001

ÖRIGINAL

Daltimure,

2401

W. Beliedere Ave, Baltimine MD 21 215

30. Nat and addr s of person who completed cause of death (Item 23a) (Type, Print)

Sinui

nui Hospital
32. Registrar's Signature

M.D.

Morey

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 8 43 AM JUL) 2007 Dorothy Marie Snyder 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Rosedale Manor Care 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours Min. 1 □ M 2 🔀 F Aug. 8, 1923 Maryland 83 215-18-7136 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2X No Rosedale Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 8100 Rossville Boulevard 21237 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna George Rony A. Kunkel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) L. Paul Snyder, Jr. (Son) 2231 Kentucky Ave., Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 07/18/2007 | Baltimore, Marylaand 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. Bucin a le 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ADVANCED Immediate Cause (Final DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery edent pregnant 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ HO 24a. Was an autopsy performed? 1□ Yes 2 INT 25. Was case referred to medical

Physician /Medical Examiner that the death certificate be executed

Physician

/Medical

Examiner

Directo

Funeral

2

Completed

Be (

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

Pages 1 and 2 should be filed went of Health and Mental Hygie int: If Item 27 is marked other

Injury or other

Maryland 21215-0036

Baltimore,

er than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

and the page certificate this After

Division or Vital Records, P.O. Box 68760.

Physician:

Hospital or Attending

24 hours a Funeral

within 2

Examiner
Physician/Medical
þ
Completed
e

Certification:

Medical

filled in by the funeral after death

IF FEMALE:
23b. Was dec
in the nas

1 🗆 Yes

in the past 12 months? 1□Yes 2□No

26. Place of Death (Check only one)

200	ю	Hospital: 1 ☐ Inpatien	t 2	ER/Outpatient	3 🗆 D0	OA Other:	4 Nursing H	ome	5 Residence	6 ☐Other (Specify
of Death		28a. Date of Injury		28b. Time of	- 2	28c. Injury a Work?	t	28d	Describe how inj	ury occurred
ral	5 Pending	(Month, Day	Year)	Injury		work?				

27. Manner of 1 Natu investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

14

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated

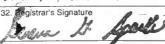
29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Awid, MD DO061789 JULY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIPPINE OFORI AWUAH, 9106 PHILADELPH (A ROAD, STE 208, BALTIMORE, MD 2/237 31. Date filed (Month, Day, Year)

State Registrar

2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend #6, perFH, G869, 7/18/07TT Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY 2007 ROBERT **SCHLENGER** 16 4:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** EDENWALD NURSING HOME TOWSON BALTIMORE If Linder 1 Year | If Linder 24 Hrs 8. Date of Birth (Month, Day, Year) 03/01/1932 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 T E 75 Director 213-28-9082 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must han mast hand han mast 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Funeral Director 1 ☐Yes 2 ☐ No MD BALTIMORE TOWSON 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 800 SOUTHERLY ROAD #1212 21286 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: Completed by 3 ☐ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) ATTORNEY LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SCHLENGER MARTHA THOMPSON P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 SOUTHERLY ROAD #1212 - TOWSON, MD 21286 GRETCHEN SCHLENGER / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CARROLL CREMATION INC: 07/17/2007 HAMPSTEAD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Jours 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 400 disease or condition resulting in death) /Medical Due to (or as a consequence Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ Ño 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 21 No Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 ☐ Yes 2 No Other: 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral L Medical 29a. Certifier 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name Albuerns

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Segistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** JULY 14 SEYMOUR SCHWARTZ 8:35P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** STELLA MARIS HOSPICE TIMONIUM BALTIMORE If Under 1 Year If Under 24 Hrs. 8. 6. Sex 1 M M 2 ☐ F Date of Birth (Month, Day, Year) 06/07/1921 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 052-12-2708 86 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Directo BALTIMORE MD OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM CT., #623 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∆∏Yes ≥ □ No ARMY If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **ACCOUNTANT** ACCOUNTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILLIAM SCHWARTZ SOPHIE WALCOFF ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12217 ROHAN COURT, OWINGS MILLS, MICHAEL SCHWARTZ / SON 20b. Place of Disposition (Name of cemeters Francisco)
MEMORIAL PARK 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 07/17/2007 RANDALLSTOWN, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PANCREATIC CANCER disease or condition resulting in death) /Medicai Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛣 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

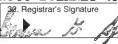
Division or Vital Records, P.O. Box 68760.

DR. TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



2300 DULANEY VALLEY RD.

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

			Please T	ype or Print in B					_		
		,	For State Registrar	State of Maryland		artment of F ctificate of		, ,	ene	7 23058	
e	Physici	an	1. Decedent's Name (First, Middle, Last) James William	Turner				2. Date of Death Month July 15	derive party of	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution, give	street and number)			r Location of Death		4c. County of Dea		
			Northwest Medical 5. Social Security Number 6. Sec		ast hirthday)	Ran	dallstown	0 D-46 Di-4h	Balti 9 Bir	more thplace (State or Foreign	
	Funeral Director		237–62–9983	M 2□F 66	Yrs.	Months Days	Hours Min.	(Month, Day, 12/4/19	Year) C. (140	NC	
0	how	_	Usual Residence of Decedent 10a. State 10b. County MD	10c. City	, Town or Lo	cation Balti	more			10d. Inside City Limits	
ale de de la de	a or 28a-f s be notified	Director	10e. Street and Number 5519 Norwood Av	renue		10f. Zip Code 21	207	10	10g. Citizen of What Country?		
036	new within 2 hours are oean with the maryand tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 25€ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi		
15-UU36	"natura	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	sing 1	6b. Kind of Business	/Industry	
717	al Hygiene. I other than "rivent, the Medi	Somp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		l'eacher			Educa	tion	
aryland	and Mental Hy Is marked othe raumatic event,	To Be (17. Father's Name (<i>First, Middle, Last</i>) Grady Richard	Turner			_	e (First, Middle, M. e Pearl S	,		
	124		19a. Informant's Name/Relationship (Ty Dorothy Turner /	wife Wife	19b. Mailir 5519	ng Address (Street Norwood	and Number or Rui Avenue,	al Route Number, Baltimor	City or Town, State, e, MD 212	Zip Code) 07	
	nent of Hez int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🛱 F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	emetery, crei	osition (Name of matory or other plain ng Churcl	h Cem. Ju		0c. Location - City of Gast	Town, State	
Balt	Department of Important: If it any injury or one		21. Signature of Funeral Service Licens	lavorall	22	2. Name and Addrescharles	L. Stever	ns Funera	1 Home In 1timore,	C.	
٥٠, ٠٥٥ ١	hysician attending physician and purish transit for use as the burial-transit	cal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ence of):	(- (7	ng, such as cardiac	1 1	YSQCSQ	Approximate Interval Between Onset and Death	
P.O. Box 687	oy the attending phy ached for use as the	Physician/Medica	IE EEMALE:	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	olivery Day Year	
	been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did toba		to the cause of death? Probably 4 Unknown	
I Kec	ate has page 2	Completed						24a. Was an autopsy perform 1 Yes 2	prior to		
or vital	is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or:	th (Check only one	/		
	ral d	tion: To	27. Manger of Death 12. Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	4 Nursing H	ome 5 ☐ Resider 28d. Describe hov	nce 6 □Other (Sp. w injury occurred	ecify)	
=	after death. Director: After din by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Str. City or Town,	eet and Number or F State)	Bural Route Number,				
	the nospital nin 24 hours a the Funeral I npletely filled	Medical C		siclan: To the best of my known the sais of examinate and manner stated.							
ļ.	within To th	Me	29b. Signature and title of cartifier	Depot	,	29c. Licens			d. Date signed (Mor		
	10		30. Name and address of person who co	11. 11 / 2	23a) (Type,	ble H	III CTI	4 thonas	Tuly 17, 2	21000	
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signar	ture	N n	1160	- Irwilli	1 10	5075	
600			SUL I O LOC	1 18 49 Ac 1 18		1651 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_	For State Registrar			ertificate of L	JU4111	H	leg. No. 🛴 📗	11 6000
Physici /Medi		1. Decedent's Name (First, Middle, La: Gilbert	st) E. Troyer				July 16	th Day 2007	3. Time of Deat 9:45 F
	4a. Facility Name (If not institution, give street and number) 625 Windsor Drive					Location of Death		4c. County of	
Funeral Director		217-16-8435	ex 7. Age ((In yrs. last birthday 83 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 6,	Year)	Birthplace (State or For Country) [aryland
how at		Usual Residence of Decedent 10a. State 10b. County	1	l0c. City, Town or L	ocation				10d. Inside City Lin
he Ma 18a-f s otified	Funeral Director	MD Carrol:	1	Westi	minster				1 □ Yes X [X
with u	ğ	10e. Street and Number 625 Windsor D	rive		10f. Zip Code 2115	5.0	1	Og. Citizen of What	
ms 23	nera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race -	American Indian,
ined within 7 inous after beath with the maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced	XXYes 2 ☐ No If Yes, Give Year or Dates: W			In, Mexican, Puerto	o Hican, etc.)	Specify:	White, etc. White
'natur dical	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	edent's Usual Occupa e kind of work done o DO NOT use retired	ation during most of worl	king	16b. Kind of Busin	
Hygiene. Sther than 'ent, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		teamfitt			Constru	strial action
d do	To Be (17. Father's Name (First, Middle, Last) Albert Troye					ne (First, Middle, i e Swem	Maiden Surname)	
and Men Is marke aumatic		19a. Informant's Name/Relationship (19b. Mail	ing Address (Street a			r, City or Town, St	ate, Zip Code)
Health em 27 I		Wayne Troyer /	Son						MD 21158
5 = 5		20a. Method of Disposition XXBurial 2 □Cremation 3 □ 4 □Donation 5 □ Other (Specifi			osition (Name of ematory or other place			20c. Location - Cit	ty or Town, State ksburg, M
Department of Important; If any injury or once.		21. Signature Fineral Service Lio	en min	2	22. Name and Addres	ss of Facility Ec1	khardt	Funera1	Chapel P. Mills, MD21
Medical xaminer		resulting in death)	a	netes.	mell	itus			Onset and Deati
/S/38	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	consequence of):	a	ital			Unset and Deatr
g physician and as the burial-transit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a c	pregnancy □Fetal death 3	□Ectopic pregnancy □ Other (specify)	itus		23d. Date of Month	of delivery
by the attending physician and ached for use as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	b. Due to (or as a condition of the cond	pregnancy □Fetal death 3 ne of death 5	Other (specify)		23e. Did tol	Month	of delivery n Day Year ute to the cause of death
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of	b. Due to (or as a condition of the cond	pregnancy □Fetal death 3 ne of death 5	Other (specify)	en in Part I.	1 □ Yo 24a. Was a autops perfor 1□ Yes	Month bacco use contribu es 2 No 3 es 24b. We pric gyed? dea	of delivery Day Year Ute to the cause of death Probably 4 Unknown autopsy findings availa
is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a condition of the cond	pregnancy □ Fetal death 3 me of death 5 not resulting in the u	Other (specify) underlying cause give unt 3 DOA Other of 28c. Injury Work	en in Part I. 26. Place of Deal	24a. Was a autops perform 1 Yes th (Check only on the Check on the Che	Month bacco use contribu es 2 No 3 es 24b. We pric gyed? dea	of delivery Day Year ute to the cause of death' Probably 4 Unknown to completion of cause autopsy findings available are autopsy findings available. If yes 2 No
is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a contribution of the contrib	pregnancy Fetal death 3 ine of death 5 interest in the understand	other (specify) underlying cause give unt 3 DOA Other of 28c. Injury Work M 1 Norm treet, factory, office	26. Place of Deater: 26. Place of Deater: 4 □ Nursing Herer 7. Arrives: 7. Arrives: 8. Arrives: 9. Arrives: 9. Arrives: 1. Arrives: 2. Arrives: 2. Arrives: 2. Arrives: 3. Arrives: 4. Arr	24a. Was a autops perform 1 Yes th (Check only on one Reside 28d. Describe house 28f. Location (St. City or Town	month bacco use contributes 2 No 3 n 24b. We pring dea 2 No 1 l 2 No 1	of delivery Day Year Ute to the cause of death' Probably 4 Unknown autopsy findings available to completion of cause th? IVes 2 No (Specify) Or Rural Route Number,
4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and ely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a condition of the cond	pregnancy Fetal death 3 lime of death 5 lime of lime of death 1 lime of death	Other (specify) underlying cause give unt 3 DOA Other of 28c. Injury Work 1 DOA treet, factory, office	26. Place of Deater. 26. Place of Deater. 4 □ Nursing Here at Processing Section 1.2	24a. Was a autops perform 1 Yes th (Check only on one 28d. Describe house 28d. Location (St. City or Town, and due to the c	Month bacco use contributes 2 No 3 no 24b. We say a decing the say of the say	of delivery Day Year Ute to the cause of death' Probably 4 Unknown accompletion of cause or to completion of cause ath? Ves 2 No (Specify) Or Rural Route Number, Her as stated.
Ifter death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a condition of the best of rainer: On the basis of experience of the basis of experie	pregnancy Fetal death 3 lime of death 5 lime of lime of death 1 lime of death	Other (specify) underlying cause give unt 3 DOA Other of 28c. Injury Work 1 DOA treet, factory, office	26. Place of Deater: 26. Place of Deater: 4 □ Nursing Horacter: (**) (**es 2 □ No	24a. Was a autops perform 1 Yes th (Check only on 28d. Describe house 28d. Describe house 28f. Location (St. City or Town, and due to the corred at the time, of the corred at the cor	Month bacco use contributes 2 No 3 n 24b. We price dear 1 Control of the control	Day Year Day Year Day Year Day Year Day Year Day Year

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Mary Turner	State of Maryland / Department of 1- For State		ygiene Reg. No.	17 2706			
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death			
Medical Examine	MARY ELLEN TURNER 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	June 27, 2007 4c. County of Dea	1752 hrs			
	8600 Mike Shapiro Dr. #802	Clinton	Prince Georg				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 78 Yr	If Under 1 Year If Under 24Hrs Months Days Hours Min.	Fore	Birthplace (State or eign Country) Virginia			
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ition		10d. Inside City Limits			
<u> </u>	MD Prince George's Clinton			1 X Yes 2 No			
the Maryland a or 28a-f show tiffed at once. Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?			
th the 23 or notific	8600 Mike Shapiro Dr #802	20735	United Stat				
r death with or items 23 cmust be no		as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		erican Indian, Black,			
safter de rral", or niner m	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2XX No specify:	Specify: B1	ack			
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21215-0036 uld be filed within 7 Mental Hygiene. narked other than c event, the Media	Edward Turner	Mari					
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene. It: If Hem 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		ng Address (Street and Number or F	Rural Route Number, City or Town, Sta	ate, Zip Code)			
e, N I and I I lealth I tem	20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery,	Date 20c. Location - City	or Town, State			
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/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Card			Between Onset and Death			
Kammer	or condition resulting in death) Due to (or as a consequence of):						
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ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
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x 68760 h certificate ending phy use as the t	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregna	23d. Date of deliverancy Month	ery Day Year			
Box 6876 Edeath certificate the attending phy ed for use as the hysician/M	1 Ves 2 No 9 M Hipknown	other (Specify)		,			
P.O. Bothat the destroy the state of detached fill by Phys	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?			
ires tha signed be det	<u> </u>		1 Yes 2 No 3 P	robably 4 🗸 Unknown			
Records, The law require, ficate has been sig, page 2 should be Completed			autopsy prior to	autopsy findings available o completion of cause of			
tal Rec			performed? death? 1 ✓ Yes 2 No 1 ✓				
Vital Rec ysician: The his certificate director, page o Be Con	25. Was case referred to medical examiner? 1 Ves 2 No. Hospital: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check					
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ion Itendir Iter: A tor: A the fu	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No					
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Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buriledical Certification: To Be Completed by Physician/Med	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.						
Z S S S S S S S S S S S S S S S S S S S	29b. Signature and title of certifier	29c. License number	29d. Date signed (A	Month, Day, Year)			
	Quel	O.C.M.E.	June 28, 2007				
F	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2120	1				
State	OOL 1 D / DH 2000	Card .					
Registrar	BANKELLE A SE	AGAIN A					

DHMH 17 Rev 1/2001

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 Sharon Taylor 13 9;26a! /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 1630 Ingleside Avenue Gwynn Oak 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 55 yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □X Days Hours Months 215-60-5002 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location r 28a-f show notified at 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MD Baltimore Gwynn Oak 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Pages 1 and 2 should be filed within 72 hours after death with t ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or; ury or other traumatic event, <u>the Medical Examiner must be nangerenent</u> 1630 Ingleside Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African-1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 ☐ Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Sinai Hospital College (1-4or 5+) 12th Elementary/Secondary (0-12) Housekeeping Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Howard Sr. Ruby Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Ingleside Ave., Gwynn Oak, MD 21207 Hubert J. Taylor/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Arbutus Mem. Park 7/20/07 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, MD 22. Name and Address of Facility Wylie F/H P.A. of Balto. Co. gnature of Funeral Service Ligensee 9200 Liberty Rd., Randallstown, MD 21133 art1. Enter the disease, or complications that cause the death shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 Yrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be exequed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 6. Miles Mo 30. Name and address of person

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Reg

565

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 7 M Du 2007 3 /Medical Larry Aaron Wallace Location of Death 4c. County of Death 4b. City, Town, or 4a. Facility Name (If not institution, give street and number Examiner time *laculand* If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. 1 M 2 □ F Director 52 MD 218-56-2506 filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at XXYes 2 ☐ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Funeral 809 Reverdy Road 21212 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎗 🗀 No Specify: þ Black 3 Widowed 4 Divorced Completed Medical 16b Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Apartment Building <u>Maintenance Worker</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Joseph Wallace Sr. Doretha Rouzer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Department of Health Important: If Item 27 any injury or other trong once. 809 Reverdy Road, Baltimore, Md 21212 Barbara wallace-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) o Crematory Inc 7/21/07 Baltimore, Md 22. Name and Address of Facility March F/H West 7/4300 Wabash Ave, Baltimore, Md 21215 Metro 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse purpose of): **Examiner** 1sease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed OCG 10 W burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a the burial Physician/Medical attending properties of the second IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours after To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Medical Examiner: On the basis of examination and/or investigation in manual in the cause (s) | 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

3

lagion Wallace

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

07-05442 Wayne White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 23063

yno vviito		- For State		Certifica	ate of i	Death				Reg. No.		U/ LU	00
Physicia		1. Decedent's Name (First, Middle,Last) Mo							Date of De Month	Day	Year	3. Time of Death 2240 hrs	
edical Examin		Wayne White July 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death							July 15, 2		inty of Dea	ath	\dashv
	1	4a. Facility Name (if not institution, given 5700 Radacke Avenue	e street and number)			Baltimore	City				NA		
Euporal			ex 7. Age	e (In yrs. last bir	thday)				8. Date of E	Birth (MM/DD/)		Birthplace (State or eign	
Funeral Director		5. Social Security Number 6. S 220-08-7204	XM 2 F	24	Yrs.	Months D	ays Hours	Min.	3-23	3-1983		Country) Md.	
	1	Usual Residence of Decedent										10d. Inside City I	Limits
v any		10a. State 10b. County		10c. City, Town								1 X Yes 2	
land f shov	호	Md. NA		Ba.	ltimo	re 10f. Zip Code				10g. Citizen	of What C	ountry?	
r 28a-	Director	10e. Street and Number 2931 Erdman Ave.				2121					USA		ļ
after death with the Maryland al", or items 23a or 28a-f show iner must be notified at once.		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	Decedent of	Hispanic Ong	in? (Spec	cify Yes or	No- 14.	Race - An	nerican Indian, Black	1
eath w	Funeral	1 X Never Married 2 Marrie	d Armed Forces	X No	ì	es, specify Cu		Puerto Ri	ican, etc.)				1
after d	by Fi		ed If Yes, Give Year			Yes 2 X		kind of wo	rk done		of Busine	ss/Industry	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	d be	15. Decedent's Education (Specify	only highest grade cor		. Decedent during mo	st of working	life. DO NOT	use retire	d)	Tob. rano	OI Duomo		-
36 in 72 h	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4 or	34)	Sto	ck Cle	ck			Ta	rget		
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, MD 21215-0036 and 2 should be filed within tealth and Mental Hygiene. tem 27 is marked other that traumatic event, the Medic	To	19a. Informant's Name/Relationship	(Type, Print) Mothe		9b. Mailing 293	Address (S	Street and Nur	nber or Ru Ba	1timo	ore, Mo	. 2	State, Zip Code)	
e, MD 2. 1 and 2 should Health and M Fitem 27 is m		Eveaine McCray 20a. Method of Disposition				ition (Name o			Date			y or Town, State	
Baltimore, permit. Pages 1 at Department of Her Important: If ite		1 X Burial 2 Cremation	Removal from S	tate crem	atory or otl	ner place)		7 1	9-07	72	hutu	s <u>M</u> d.	
timor I. Pages tment of rtant: If		4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	ify:	Art	22. N	Mem .	ress of Facili			F.H.		5 . 110.	
Baltimore permit. Pages 1 a Department of Hi Important: If it		40.00	W) 0, 000	\sim	1	101 E.	North	Ave.	, Bal	timore	, Md	. 21202	
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Adminici		or condition resulting in death)	Due to (or as a con	sequence of):			-						
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ires that the signed by										Was an	1 24b. W	ere autopsy findings	available
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Reco							Discost Day	th (Charle		Yes 2 No	1 9	✓ Yes 2	No
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medical examiner?	Hospital:	atient 2 El	R/Outpatie		.Place of Dea Other		ng Home	5 Resider	ice 6 🗸	Other: Scene	
Division of Vital Records, tal or Attending Physician: The law requinrs after death. After this certificate has been she fine in by the funeral director, page 2 should it led in by the funeral director, page 2 should it	F	1 Yes 2 No	28a Date of	Injury 2	8b. Time o		c. Injury at W		28d. Des	cribe how inju	ry occurre	d	
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Div ital or rat Di	Cortification.	3 Suicide 6 Could determ	nined (Specify)	Parking Lot								more City, Md.	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Purnarial Director: After this certificate has been signed by the attending. The proper application of the purpose 2 should be detached for use as to	1		ysician: To the best on the basis of endiners of the basis of the basi	f my knowledge	, death occ	curred at the ti	ime, date and	place, and occurred	d due to the at the time	e cause(s) and , date and pla	d manner : ce, and du	as stated. ue to the cause(s)	
Fo the vithin Fo the	Modical	one 2 Medical Exam	and manner stat	ed.			License numb			29d. [Date signe	d (Month, Day, Year))
	Z	29b. Signature and title of certified	BUID				O.C.M.E.			July	16, 200	07	
		1 ande	KIN)	of death (Item ?	(3a)								
$ \emptyset $		30 Name and address of person Laron Locke MD. As	who completed cause ssistant Medical I	Examiner	111 Pe	nn Street,	Baltimore,	MD 21	201				
	 Stat	31. Date filed (Month, Day, Year)	32 Regi	strar's Signature		de						-	
Reg		1111 4 6	2007	yes di.	Jan Jan								

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State

Registrar

29b. Signature and title of certifier

32. Registrar's Signature 31. Date filed (Month, and the State of the said

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

and manner stated

mp

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

111 Penn Street, Baltimore, MD 21201

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 15, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar	Ce	ertificate of De		Reg. No.		
Ī	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)	W	right	-		13 200	
	Examin		4a. Facility Name (If not institution, give street and number)	11 1	4b. City, Town, or Lo		•	4c. County of Deatl	
			Shady Grove Adventist 5. Social Security Number 6. Sex 7. Agr	e (In yrs. last birthday	Rockv	f Under 24 Hrs 0	Date of Birth	Montgome 9. Birth	Pry place (State or Foreign
в	Funeral Director		230–26–2643	91 Yrs.	Months Days I	Hours Min. N	(Month, Day, Ye	1915 V	irginia
	ט		Usual Residence of Decedent					7	404 1-14- 02-11-24
	arylan show d at	_	10a. State 10b. County	10c. City, Town or L	cocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he Ma 28a-f	Director	Maryland Montgomery 10e. Street and Number	Clar	ksburg 10f. Zip Code	·	100	. Citizen of What Co	
	with ta or the n	اق			2087	71	1.03	USA	,
	ms 23	Funeral	P.O. Box 429 11. Marital Status 12. Was Decedent	/ Yes or No- an, etc.)					
ထွ	filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural" or items 23a or 28a-f show ther than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at		Armed Forces? 1 □ Never Married 2□ Married 1 □ Yes 2 ☑ If Yes, Give			Specify:	an, etc.)	Black, White	
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ă	al Oire	Certification:	4 Homicide determined building, e	іс. (Бресіту)			City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificy completely filled in by the funeral director,	Medical (29a. Certifier (Check only one) 1 CertifyIng Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or					
	To the within To the	Me	29b. Signature and title of certifier		29c. License r	number		d. Date signed (Mon	
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				np 91	Im 28611	17041106	- Gui	II S DWG	7. 1711
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2, 24a per dr., g869,07.18/200/
Reg. No. Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 07/01/2007 3. Time of Death Month LIAN E. WILLIAMS **Physician** 10:35 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 1106 WAMPLER ome BAHIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) January 2 1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Months Yrs 266 30 8291 80 Connecticut **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Baltimore Maryland Baltimore County Directo 1 ☐ Yes 2XXNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1106 Wampler Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 🏋 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2100No Specify þ Specify: 3 Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Housekeeping-own Home Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John R Unnever Nellie E Finnerty ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Fay 2413 Perry Avenue Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gans. July 6 2007 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. San at ire of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral Hone Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Use to (or as storm / quence of): YPAIS /Medical Examiner NOUTOPENIK Sequentially list conditions, if any, leading to immufact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (a) as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the as use IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 □Ectopic pregnancy for Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknow ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only the 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (Month, Day, Year)

9/10 Philosophia Ro #314,

mel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7.15AM m 7 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 92Vin Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country)
 Tink **Funeral** 1 M 2 □ F Months Days Hours Min. unk 92 Oct. 23, Director 1914 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Director XXYes 2 □ No 10e. Street and Number 22 South Athol Avenue 10f. Zip Code 10g. Citizen of What Country? 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status unk Black, White, etc. ☐ Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 2 □ No **unk** unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Bellamy / Guardian 10 S. Calvert Street; Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₭ Burial 2 Cremation 3 Removal from State Mount Zion Cemetery 07/18/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217 23a Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** na disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 5 squaritistry list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed that initiated events resulting in death) Last burial-trai Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) P.0. □Yes 2□No detached the signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy perforn 2 No 1∐ Yes 2 2 No 1 ☐ Yes or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes **E** 2 ER/Outpatient 3 DOA 1 ☐ Inpatient မ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 ☐ Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

T. Ballinne MD2/20)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

82

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3, Time of Death 2. Date of Death ^{Day} 2007 JULY 10, **Physician** 1:00p M ESTHER J. WINCKLER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GILCREST HOSPICE CENTER TOWSON BALTIMORE Date of Birth (Month, Day, Year) 5-13-1915 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Days Hours Min. MARYLAND 92 218-26-2072 Director Usual Residence of Decedent the Maryland a or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Tyes 2 □ No Director MD. N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. 2121 WINDSOR GARDEN APT. B522 21207 USA ral", or Items 23a (Examiner must b by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify 3 Widowed WDivorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) the Me Elementary/Secondary (0-12) HOUSEWIFE HOMEMAKER 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERTIE DAVIS WALTER DAVIS P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I SAUNDRA SPENCER (DAUGHTER) 3201 DORITHAN RD. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of P Important: If ite any injury or ot once. 1 XBurial 2 ☐ remation 3 ☐Removal from State HOPKINS UNITED METH 7-17-2007 CLARKSVILLE, MARYLAND 4 ☐ Donation Other (Specify) 21. Signature of Funeral Service Licensee ONATHAN D HIBNER Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N, MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Prite the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediat • Caure (Final disease or condition resulting in death) OS! **Physician** Se eveck /Medical Due to (or as a contequence of): diverticular ASSCERS Examiner JIVEZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of contifier · cus 30. Name and address of person who completed cause of death [t.m. 23a) (Type, Print) 701 BMC 31. Date filed (Month, Day, 32. Registrar's Signature Year

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar		y rairra	Cer	tificate of	Death	14 11101114	Reg.	No. 2007	23065	
4	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Month						
	- /Medic		Shirley A. And						Jun	.e 2	28, 2007	9:45 P M	
	Examin	er	4a. Facility Name (If not institution, giv		1.0		4b. City, Town, o		Death	,	4c. County of Death		
	Funeval		11801 Rockville 5. Social Security Number 6.5		1 Z (In yrs. las	at birthday)	Rockv:			of Birth	Montgon 9. Birth	nery place (State or Foreign	
	Funeral Director			1□M 2□F	85	Yrs.	Months Days	Hours	Min. (Mo.	nth, Day, Yes	ar) Cou	ew York	
	yland at		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits	
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	or 28	by Funeral Directo	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Cou	ntry?	
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_	ter de ritem iner r	Fun	11. Marital Status 1 ☐ Never Married ② Married	12. Was Decedent E Armed Forces? 1 Tyes 2 17 N		IS. V	Vas Decedent of H Yes, specify Cuba	an, Mexican, F	Puerto Rican, e	etc.)	Black, White,		
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N D	filed v Hygie ther i		17. Father's Name (First, Middle, Last	l Year		ROOK	keeper	18. Mother's	s Name (First,		Private den Surname)		
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I flem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Max Cooper	,					ye Grab		,		
<u>a</u>	shou and M s mar umat	۲	19a. Informant's Name/Relationship (Type. Print)	1			and Number	or Rural Route	Number, Cit	ty or Town, State, Zij	,	
Σ,	and 2 ealth n 27 is		Irving Andrusia	- Husband		11801	Rockvil:	le Pike	e, # 16	12, Ro	ockville,	Md. 20852	
<u>5</u>	ges 1 t of H if iter		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State	20b. Plac	ce of Dispos netery, crem	sition (Name of natory or other plac		Date		. Location - City or T		
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<u>a</u>	Depar Impol any ir		21. Signature of Funeral Service Lice	Dtattlena	uch	EĎ	Name and Addre	EL FUNI	ERAL DI	RECTION	ON, INC. LE, MARYLA	ND 20852	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.	Do not ente	er the mode of dyir	ng, such as ca	ardiac or respira	atory arrest,	in, imitin	Approximate	
F	Physician		Immediate Cause (Final disease or condition				ortic An					Interval Between Onset and Death Months	
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	Examiner [.]		Sequentially list conditions.	Ų, <u> </u>	OP D							Years	
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a		nce of):						Vacua	
•	execut and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	AD_ a consequer	nce of):						Years	
00100	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			_d. P	neumo	nia						Years	
9	rtificat ng phy as th	Medical											
5	ath cer tendir		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p	of pregnanc 2 □ Fetal d		Ectopic pregnancy	,			23d. Date of deliv	ery Day Year	
5	w requires that the death ce been signed by the attendi should be detached for use	Physician/	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	th 5□	Other (specify)				Month	Day rear	
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5	hysik this co	2	1 ☐ Yes 2 📉 No				3□ DOA Oth	4 🗆 IVUISI			e 6 □Other (Speci	fy)	
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	ai or / s after if Dire	Certification:	4 ☐ Homicide determined	building, etc	(Specify)				City	or Town, Si	tate)		
:	To the Hospital or Attending Physician: The law within 24 bours after due. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) 1X Certifying Pt 2 Medical Example 1X Certifying Pt 1X Cert	nysician: To the best of miner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tirestigation, in my o	me, date and popinion, death	place, and due occurred at th	to the cause e time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
1	To th To th comp	Me	29b. Signature and title of certifier	.000	- 0		29c. Licens	e number			Date signed (Month,		
	10		30. Name and address of person who	completed dayse of de	eath (Item 2		D313				June 29, 2		
			Suhair Abulfan		1521	5 Sha	dy Grove	Road,	Suite	100,	Rockville	, Md 20850	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ır's Signatur	re Ly A	- P - 0						
	negistr	αι	JUL - 9 2	July Beele	2 2	y for	MARKEN !						

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Center

7. Age (In yrs. last birthday)

99

4a. Facility Name (If not institution, give street and number)

6. Sex

1 □ M 2 🗓 F

North West Hospital

5. Social Security Number

217-26-6228

Usual Residence of Decedent

4b. City, Town, or Location of Death

Randal1stown

Months

If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min.

3. Time of Death

9. Birthplace (State or Foreign

Maryland

4c! County of Death

8. Date of Birth (Month, Day Year) Aug 29 1907

Aug

Baltimore

O

UG

/Medical Examiner

Funeral

Director

10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 XNo Lothian Maryland Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1267 Marlboro Rd. 20711 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 12th 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Brown John Henry Thomas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9708 Kerrigan Ct. Randallstown, Md. 21133 Betty Chase(Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Baltimore, Md. Woodlawn Cemetery : 7-5-07 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Williame and the seof Pacilitisons Mortuary, arry B. Reese MOOY8 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MELIMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): INFECTION' Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transi Due to (or as a consequence of): FAILURE HEART Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the and be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy pertorm 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day 1 Natural 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

IDBINDER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 0 2 200

MORTHINES

HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** BROCCA ERMINDA 12:40 PM 2, 2007 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 19038 Montgomery Village Avenue Gaithersburg Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2X F Director Oct 14, 1913 Brazil Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No 28a-f sh notified Director Montgomery Village/ Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be re-19038 Montgomery Village Avenue 20886 Brazil Pages 1 and 2 should be filed within 72 hours after death venent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23i Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🟋 No Specify. Completed by 3 Widowed 4 □ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Servant Brazilian Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Judith Virginia Chaulet ပ Joao Beux or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19a. Informant's Name/Relationship (Type. Print) Sandra B. Vieira/daughter 19038 Montgomery Village Ave. Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of h Important: If ite any injury or ot 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 07/05/07 Beltsville, MD Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signat@e of Funeral@ervice MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INCUMONIA disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ NEURALCIA INTRACTABLE TRIGEMINAL 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has l page 2 s performed 2 **1** No certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 21-N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After s after deam. ral Director: Aftr 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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Registrar

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State

4343 MUNTGORERY N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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QUINIS M.D.

32. Pogistrar's Signature

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2007

31. Date filed (Month, Day

JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 2, Year **Physician** 2007 8:26 Ам Georgia M. Burton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Harmony Hall | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan, 27), 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 23 1 □ M 2 😾 F North Carolina Jan. 84 Director 261-48-9496 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No notified Director MD Columbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ms 23a or 7 21044 USA 6336 Cedar Lane #328-B Funeral urai", or items 2 i Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1944–45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Peebles Henry Motsinger ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5111 Golden Leaf Ct. Ellicott City, MD 21043 19a. Informant's Name/Relationship (Type. Print) Sheron B. Marshall/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: if it any injury or or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/05/07 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Sen Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sugar disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Monknown certificate has been si rector, page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence ٥ 1 Yes 2 No 2 ER/Outpatient 3□ DOA 6 Other (Specify 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

10820 + 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar

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32. R

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 2358 28 DEE ANNE BLADES June 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Memorial Hospital easton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖔 F Months Days Hours Min. JULY 6, MARYLAND 1947 59 215-50-8054 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director RIDGELY CAROLINE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21660 11101 HOLLY ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE ģ Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) ELEMENTARY EDUCATION TEACHER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DELIAETTE NOBLE JAMES DALLAS BLADES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO BOX 1209, RIDGELY, MARYLAND 21660 PATRICIA A. LEWIS/FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 remation 3 ☐Removal from State STEVENSVILLE, MARYLAND CHESAPEAKE CREMATION CTR 7/2/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST EASTON, MD 21601 MERLEROI NOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, loading to limited at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) the 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 21110 3 Probably 4 Unknown 1 Tes page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performe 2 Physician: 25. Was case refe led to medical examiner? funeral director. 26. Place of Death Check onl one 21 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 🗌 Yes Certification: To this . Manner of Dea 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death 24 hours after death Property Proctor: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated within 2 pkyslan 29c. License number d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ere Grood man 10 cause of death (Item 23a) (Type, Print) 30. Name and address of person State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Deatl Year **Physician** Baker , Jr. 2007 1:40 A M Stuart July 3 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Months Hours 1 X M 2 □ F 55 Director 219-60-3360 July 28,1951 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f sh must be notifled 1X Yes 2 □ No Director Maryland Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 36 Pennsylvania Ave. 21157 items 23a United States permit. Pages 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examiner must any liqury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stuart W. Baker Helen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3893 Sells Mill Rd./ Taneytown, Maryland 21787 Richard Baker / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Beth Shalom Cem. 07/04/2007 |Taylorsville, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 er 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0.441 Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Quamous all attending physician and for use as the burial-tran that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760 Venous Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🍽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29a. Certifier Medical

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State Registrar

completely

the

(Check only one)

29b. Signature and title

31. Date filed (Mosth

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRAVEEN BULARUM 196 TJ DRIV

Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00062223

196 TJ DRIVE, # 230, FRED CALCK MD 21702

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 JULY 4 JACQUELINE ANN BRUNSCHWYLER 8:35 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 11309 KENILWORTH AVE. GARRETT PARK MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | JULY 10 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 20 F n 1933 73 563-48-7007 Yrs. CA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location r than "natural; or iteme 23a or 28a-f ehow the Medical Examiner must be notified at MD MONTGOMERY GARRETT PARK 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11309 KENILWORTH AVE. 20896 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?/ 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked of EDWARD WILLIAM ROULEAU MABEL MORGAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is eny injury or other trau PHILIP BRUNSCHWYLER/SPOUSE GARRETT PARK, 11309 KENILWORTH AVE., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State STAUFFER CREMATORY 7/5/07 FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fment Selvice Ligensey 22. Name and Address of Facility
HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LYMPHOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any aution to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No certificate 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) ieral Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier dua D20367 JULY 5, 2007 MID

State

Registrar

O. Box 68760.

20850

JOEL KALMAN, MD 1396 PICCARD DR., ROCKVILLE, MD

32. Sigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2007 July Mary Catherine Banks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Hospital 5. Social Security Number 6. Sex St. Mary's Leonardtown Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 M 2 X F Yrs. 79 04/27/1928 Maryland Director 212-74-4079 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other traumatic event, the Medical Examinar many injury or other many i 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20653 United States 46663 Yorktown Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black ģ 3 ☑ Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Care Giver Domestic 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Ashton Mary Catherine Dyson ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21366 Lexington Drive, Great Mills, Maryland 20634 Carolyn E. Butler/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Queen of Peace Cem 07/12/2007 Helen, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Solvice Edward N. Br Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 17975 (-14PUXIC **Physician** /Medical Due to (or as a consequence of): 19975 Examiner Caldio-or Sp Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 1)97 5 50751 requires that the death certificate be executed and use as the burial-tra Due to (or as a consequence of): 14 fechel 175 Physician/Medical UNNKLY IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by nemenha 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown happer tonslu 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy page performed? Yes 2 No Renal ta11918 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No

Vital ō the Hospital or Attending To the ...
Within 24 hours are...
To the Funeral Director:

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

D0061719

(Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24035 Three Notch Rd. Hollywood MD 20636

July 8, 2007

State Registrar

/hanan lay

| hours after death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** Martha Brooks Briscoe Ju1v 08 2007 /Medical 6:10 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 17705 Point Lookout Road Park Hall St. Mary's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🏋 F Director 81 220-16**-**8727 08/30/1925 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the MALATE. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland St. Mary's Park Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17705 Point Lookout Road Funeral 20667 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3altimore. Maryland 21215-0036 1 ☐ Yes 2 X No Completed by Specify Specify: 3 ₩ Widowed 4 Divorced Black. Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Marshall L. Brooks Martha Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47335 Amanda Street, Park Hall, Maryland 20667 Lorraine Williams/ Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Peter Claver Cem. 07/13/2007 | St. Inigoes, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. uneral Sen M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheim cos **Physician** 15dase disease or condition resulting in death) orsi /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as t IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ H0 24a. Was an autopsy perform 2 🗆 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 10 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Doath 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David M. Federle, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland / Dep	artment of F			2007	00070
			Registrar 1. Decedent's Name (First, Middle, Las	at)		runcate or	Dealli	2. Date of Deat	eg. No. UU/	3. Time of Death
	Physici			,,,				June 27	Day Year	7:00 P
To.	/Medic Examin		Manuel Boluda 4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Deatl		4c. County of Dea	
	ZX		Holv Cross Hosp	ital	2	Silve	er Spring	r	Montgo	omerv
13/2	Funeral		Social Security Number 6. S		e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign ountry)
-	Director		213-56-2117 Usual Residence of Decedent	A	75 Yrs.			Oct 30,	1931 Sp	ain
	/land ow at		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland Mont	gomery	Silv	er Spring	3			1 □Yes 2X No
	ith the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	s 23a	ral	1506 Overlook D		I 40		903		USA 14. Race - Ame	- India
	ter de item	Funeral	11. Marital Status 1 ☐ Never Married 25 Married	12. Was Decedent Armed Forces? 1 Tyes 27	Everin U.S. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerl	o Rican, etc.)	Black, Whi	
980	urs af al", or Exm	by	3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ▼ If Yes, Give Year or Dates:		1☐XYes 2☐ No	Specify:	ain	Specify:	Thite
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a. Dece	edent's Usual Occup	ation		16b. Kind of Business	
2	ithin ne. han " e Mec	mple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	e kind of work done DO NOT use retired		and g		
2	filed w Hygie other th		17. Father's Name (First, Middle, Last,	4		Accounta		ne (First, Middle, M	Self Emp	loyed
Maryland	d d d	o Be							maiden barriame)	
37	2 should be filed and Mental Hygi is marked other aumatic event, ti	_C	Manuel Boluda 19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street		o Peiro ural Route Number,	City or Town, State,	Zip Code)
Š	permit. Pages 1 and 2 should Department of Health and Mer Important: if item 27 is marke any injury or other traumatic once.		Raquel Boluda/S	pouse	1506	Overlook	c Dr. Sil	ver Spri	ng, MD 209	03
Baltimore,	of He of He roth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	-	20b. Place of Disp		1		20c. Location - City or	
Ĕ	permit. Pages Department of I Important: If ite any Injury or of		4 □ Donation 5 □ Other (Specif		Gate of	Heaven Ce	m Jun	30, 2007	Silver	SPring, MD
Sail	ermit Depart Dep		21. Signature of Funeral Service Licer	is e	1-				ldi Funera	
	405 80		23a Part1. Ent the disease, or com	plications that source						ng, MD 20904 Approximate
			shock, or peart failure. List only	one cause on each li	ne.			or respiratory arre	751,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Anoxi	c Encepha	alopathy			3 days
	Examiner					opulmonar	v Arrest			3 days
V		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):		,			
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		rrent Res	piratory	Failure		l_month
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical E		Due to (or as	a consequence of):	1	***			1
687	ficate phys s the	edic		.d	Diaj	hagmatic	weakness	i		1 month
	death certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	elivery
P.O. Box	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at		□Ectopic pregnancy □ Other <i>(specify)</i> _	/		Month	Day Year
o.	at the by th	hys	9 ☐ Unknown	9□ Unknown						
	w requires that the di been signed by the should be detached		Part II. Other significant conditions of		· ·					o the cause of death?
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Vital	Attending Physician: r death. ector: After this certifice by the funeral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Oth	or:	th (Check only on	e) ence 6 □Other (Spe	naifu)
ō	ding Phys n. After this funeral dir	\vdash	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Time				w injury occurred	ecny)
Ö	ath. vr. Aff	atio	1X Natural 5 ☐ Pending investigation		y rear/ Injury		Yes 2∐No			
Division or	i or Attend after death. Director; /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	∠8e. Place of inj	ury - At home, farm, s c. <i>(Sp</i> ec <i>ify)</i>	reet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	lural Route Number,
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	24 ho 24 ho Fund etely f	Medical	29a. Certifier 1 A Certifying Ph (Check only one) 2 Medical Exar	ysician; To the best niner: On the basis o and manner st	of my knowledge, dea f examination and/or i	th occurred at the til nvestigation, in my o	me, date and place opinion, death occi	e, and due to the ca irred at the time, d	ause(s) and manner a ate and place, and du	e to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Mec	29b. Signature and title of certifier			29c. Licens	e number	25	9d. Date signed (Mon	th, Day, Year)
	->-0		Dem MAN	M	D	D3	36252		June 28,	2007
16	5)6		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	, Print)				
*****			Steven Kar		10605	Concord S	St, Ste.	300, Ken	sington, M	D 20895
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	land.				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29°, **Physician** 2007 10:20A.M June Τ. Barber Donald /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Riverdale Crescent City Center 8. Date of Birth (Month Day, Year)
July 10, 1930 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**∀**M 2□F Pennsylvania 76 176-22-2430 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1**X**]Yes 2□No Director Maryland Prince George's Greenbelt 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ıral", or items 23a or Examiner must be i 20770 United States 36L Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 Is marked other than " r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event Be Powel1 Barber Agnes Christopher P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 36L Ridge Road Greenbelt, Maryland 20770 Eunice S. Barber -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 7/3/2007 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signafure of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA Honal 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Pulmonary Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) burialphysician Physician/Medical the attending IF FEMALE for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9☐Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advanced Dementia 1 Tes 2 No 3 No Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? ∕es 2∭XNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**_X**No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပို this funeral Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? After t Certification: Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be

that the death certificate be executed Box 68760, P.O. Division or Vital Records, e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the the filled in by To the Hospital of within 24 hours at To the Funeral D completely

Maryland 21215-0036

Baltimore,

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saadia Husain, M.D. 4409 East West Highway Riverdale, Maryland 20737

determined

31. Date filed (Month, Day, State 2007 Registrar

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier





1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D64208

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

June 29, 2007

DHMH 17 Rev 1/2001

State

Registrar

5 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / State of Maryland / For State of Maryland /	Certificate of Death	rental mygle: Reg.	110000	23081
			Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physici /Medic	_	George Albert Clements Sr.		July 8,	2007	2:00 p ^M
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Charlotte Hall Veterans Home 5. Social Security Number 6. Sex 7. Age (In yrs. last by	Charlotte Hall	8. Date of Birth	St. Mary's	place (State or Foreign
	Funeral		1⊠M 2□F	Yrs. Months Days Hours Min.	(Month, Day, Ye 03/28/19	ar) Cour	ntry)
	Director		213-38-0682 /1 Usual Residence of Decedent		03/20/19		
	yland how at		10a. State 10b. County 10c. City, To	wn or Location		1	10d. Inside City Limits
	e Mar ta-f sl	ctor	Maryland St. Mary's Charlo	tte Hall			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	itry?
	be filed within 72 hours after death with the Maryland ttal Hyglene. dother than "natural", or ttems 23a or 28a-f show event, the Medical Examiner must be notified at	ral	29449 Charlotte Hall Road 11 Marital Status 12, Was Decedent Ever in U.S.	20622		ited State	
	ltems	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ XYes 2 □ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
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,			30. Name and address of person who completed cause of death (Item 23a				
				1 Road, Prince Freder	ick, MD 20	0678	
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27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and duty of series 29c. License number 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Name and address person who completed cause of death (Item 23a) (Type, Print)	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Certifier (Check only one) 29d. Date signed (Month, Day, Year)	B	examiner?	Other			
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and dud to the cause (s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 7-(1-07) 30. Name and addr ss. person who completed cause of death (Item 23a) (Type, Print)	29a. Certifier (Check only one) 29a. Certifier 29b. Signature and title of certifier 29b. Signature and dudr as a person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650	ertifica	3 Suicide 6 Could not be	actory, office			Route Number,
30. Name and addr ssr person who completed cause of death (Item 23a) (Type, Print)	30. Name and address person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650		(Check only 2 Medical Examiner: On the basis of examination and/or investig	urred at the time, date and pla gation, in my opinion, death o	ace, and due to the cau ccurred at the time, dat	use(s) and manner as sta te and place, and due to	ated. the cause(s)
30. Name and addr-ss // person who completed cause of death (Item 23a) (Type, Print)	30. Name and addryss of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650	Me	29b. Signature and title of certifier		290	d. Date signed (Month, D	Pay, Year)
30. Name and addr es all person who completed cause of death (Item 23a) (Type, Print)	30. Name and addr ss person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650		· commo	H00557	51	7-11-0	7
	Jennifer Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650		30. Name and addr as a person who completed cause of death (Item 23a) (Type Print)			1 11 0	,
	04 D 4 M 4 M 4 D 4 M 4	Į,			205 1000	ardtarm MD	20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician WILLARD DERRICK 1:30 P M 2007 JUNE 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1001 Ashland Drive Montgomery Ashton If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 80 578-28-9879 Washington, D.C. Director Aug. 6 1926 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural" Anna Commarked other Anna Commarked 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Md. Montgomery Ashton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Ashland Drive 20861 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Be Completed by 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) President-C.E.O. Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FLORENCE NEWQUIST HOWARD LUTHER DERRICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN T. DERRICK / WIFE 1001 Ashland Drive, Ashton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery 7/6/07 Rockville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home mure P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LIVER FAILURE **Physician** WEEK /Medicai Due to (or as a consequence of): Examiner CARCINOMATOSIS MONTH Sequentially list conditions, if any leading to influence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (unas a nunsequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) aftending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BLADDER CARCINOMA 2 No 3 Probably 4 Unknown 1 ☐ Yes LEFT RENAL PELVIS CARCINOMA INSITY. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of erform fo the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0037359 10+1 Kris M. Shekitka, MD 20832

DHMH 17 Rev 1/2001

State Registrar

Division or Vital

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month 1. Decedent's Name (First, Middle, Last) Year John J. Deherty

4a Facility Name (It not institution, give street and number)

Washing ton Advertist Hospital 21:22 2007 06 4b. City, Town, or Location of Death 4c. County of Deeth Topoma Park, mb

Montgamer 9

29d. Date signed (Month, Day, Year)

6/30/07

Physician /Medical

Funeral Director

important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be nothing at

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylend Depertment of Health end Mentel Hygiene. Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner attending physician end I for use es the bunel-trensit To the Hospital or Attending Physician: The law requires thet the death certificete be executed certificate has been signed by the a irector, page 2 should be deteched within 24 hours efter death.

To the Funeral Director: After thi
completely filled in by the funeral

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL - 3

Division of Vital Records, P.O. Box 68760.

5. Social Security N	Number	6. Sex	7. Age (In yrs.	last birthday)		r 1 Year	If Under		8. Date of E	Birth	9. Birthplece (Country)	State or Foreign
100-20-1	899	123 M 2□ F	80	Yrs.	Months	Days	Hours	Min.		24, 1926		nd
Usual Residence of												
10a. Stete	10b. County		10c. Ci	ty, Town or Lo	cation						10d. In	side City Limits
Maryland	Mo	ntgomery		c i	1 22.22	Cari	200				11	☐Yes 2√ No
10e. Street end Nu		iregomery	Ì	D.T.	lver		ig			10a. Citizen of	What Country?	
		ld Road,	C17 210				0000					
	racerie			10 10	Man Dana	dont of Life	2090		anifu Van ar I		Ireland	lian
11. Maritel Status		Armed Fo		7,5.	f Yes, spe	cify Cubar	n, Mexicar	n, Puerto	ecify Yes or I Rican, etc.)	Bla	ick, White, etc.	arcar i,
1 Never Marr		If Yes, Gr	VO TATATE		1 🗆 Yes	∲ √ No	Specify:			Specia	∕White	
3 Widowed		Year or D	ates:									
(Spec	 Decedent cify only highes 	's Education t grade completed)		16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa ork done d	ition <i>uring m</i> os	t of work	ing	16b. Kind of E	Business/Industry	
Elementary/Seco	ondary (0-12)	College (1-4or 5+)	life.	DO NOT U	ise retired))					
		5+			H	igh S			eacher		ic Educa	tion
17. Father's Name	(First, Middle, L	Lest)					18. Mothe	er's Nam	e (First, Midd	lle, Maiden Surnai	me)	
Thomas	O'Doher	ty					El	sie	Mahon			
19a. Informant's N	ame/Relationsh	nip (Type, Print)		19b. Maili	ng Address	s (Street a	and Numb	er or Ru	ral Route Nun	ber, City or Town	n, State, Zip Code)
Marilyn .	7 Dobo	m+++/1/14 f .		2.	111 6							MD 209
20a. Method of Dis		TCALMITE	20b.	Place of Dispo	sition (Na	me of	rieto	ROS	Date Date	19, Silv 2 c. Location	City or Town, S	ng, III
		3 □Removal from	State	comotory, cre	maiory or c	ourier prace	-)		July 3	3		
	5 ☐ Other (Sp		rie	-	politan Crematory 2007 Alexandria, Virginia							
21. Signature of Fu	uneral Service L	Licensee		Fi	2. Name ar	nd A pres	Coll	ins	Funera	1 Home 1	Inc.	
1. 60	SV. O.									Silver Sp		D 20901
23a. Parl 1. Enter t shock, or hea	the diseese, or a art failure. List o	complications that conty one cause on e	ach line.				g, such as	cardiac	or respiratory	arrest,	Inter	oximate vat Between et and Death
Immediate Cause disease or condition	on	T	yvord	Canc	en						400	cefs
resulting in death)		a	Due to (or as a consec	onsequence of):					4 weeks		
		H	gper te	nSion							unknow	
Sequentially list co	nditions	b		or as a consec								
Sequentially list co if any, leading to in cause. Enter Under	mmediate erlying	,			. ,							
Cause (Disease or that initiated events	'injury	C	Due to (or as e conseq	neuce of).							
resulting in death)	Last		240 (0 (1	or as 0 001130q	001100 017.							
		d										
							4.5					
Part II. Other signif	sulting in the u	nderlying (cause give	n in Part	i.		d tobacco use co					
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										as an autopsy rformed?	available	topsy findings a prior to ion of cause ?
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25 Was case refer	red to medical						oc Dia-	of Da-				
25. Was case referred to medical examiner? 1 Types 287 No. Hospital: 1 Types 287 EP/Outer						Othe			th (Check onl			- 10:
1 Inpatient 2ki Envoutpa						OA Inium	4 🗆 No	rsing H	Home 5 Residence 6 Other (Specify)			
27. Manner of Deat 1 ☑Natural 2 ☐ Accident	5 Pending investig	ation	of Injury th, Dey Year)	28b. Time o Injury	M :	28c. Injury Work 1 ☐ \	at ? ∕es 2□	No	280. Describ	e how injury occu	11190	
3 ☐ Suicide 4 ☐ Homicide	6 Could n determi	and 200. Fidus	of Injury - At h	ome, farm, str	eet, lactor	y, office			28f. Location City or	(Street and Num Town, State)	ber or Rural Rou	te Number,

DHMH 16 Rev 6/95

20+1

State

Registra

(parti)

30. Name and address of person who completed cause of death (Item 23a) (Type, Printy Kinbuly N. Treat, MD 1600 Carroll Art, Takoma Park, MD 20912

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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		For State Registrar		State of	f Marylan		artment of <i>rtificate o</i>				giene Reg. No. '	2007	23085
Physicia		Decedent's Name RT	(First, Middle, L	ast) DONALD	DEVANE	Y				2. Date of De Month JUNE	ath Day 21, 20	Year	3. Time of Death 7:59 A M
/Medic Examin		4a. Facility Name (If					4b. City, Town	, or Locatio	n of Death			County of Death	
LXdiiiii	iÇi	Shady Grove	Adventis	t Hospital			Rock	ville			Мо	ntgomery	
Funeral		5. Social Security No	umber 6.	Sex	7. Age (In yrs.		If Under 1 Ye Months Day		er 24 Hrs.	8. Date of Birt (Month, Da	th y, Year)		nplace (State or Foreign untry)
Director		413-78-9618		1 M 2 □ F	57	Yrs.				Nov. 11,		Tenne	essee
and w		Usual Residence of 10a. State	10b. County		10c. Cif	y, Town or Lo	cation						10d. Inside City Limits
Maryl f sho ied al	tor	Maryland	Montgom	o r v	C	larksbur	ø						1 ☐ Yes 2 🖔 No
r 28a	Director	10e. Street and Num				Larmotar	10f. Zip Code)			10g. Citiz	en of What Co	untry?
h with	al D	23160 Timbe	r Creek L	ane			208	71			Unit	ed State	s
ems ser mu	Funeral	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Decedent of If Yes, specify C	f Hispanic (Origin? (Spe	cify Yes or No Rican, etc.)	ı- 1	4. Race - Amer Black, White	
or ite	y Fu	1 Never Marrie		1 ☐ Yes If Yes, Giv	2₫No ve		1 □ Yes 2 🖾 N			,,		Specify:	
ural",	d by	3 ☐ Widowed		Year or D	ates:	10a Daga	dent's Usual Oc					nd of Business/l	White
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withi iene. • than	Completed	Elementary/Secon	ndary (0-12)	College (1 4	. ,		utive	,			E	nergy	
il Hyg Il Hyg other	a)	17. Father's Name (First, Middle, La	st)			-	18. Mo	ther's Name	(First, Middle,	, Maiden	Surname)	
Jenta be Aenta rked ric ev	To B	Richard	George	Devane	ey.			Vi	rginia	Co	11um		
sho and has ma		19a. Informant's Na	me/Relationship	(Type. Print)		19b. Mailii	ng Address (Stre	et and Nun	nber or Rura	l Route Numb	er, City or	Town, State, Z	(ip Code)
and and n 27		Stephanie D		daughter			erbywalk			a, Georg		319	
ges 1 t of H if iter		20a. Method of Disp 1 Burial 2		Removal from		Place of Dispo cemetery, cre	sition (Name of natory or other	olace)	: [:	ate	20c. Lo	cation - City or	Town, State
tmen tant:			Other (Spec	·/	Oa	akhill C			Jun 26			sport, Te	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midrial Examiner must be notified at once.		21. Signature of Fu	heral Service Lic	h / bu	· _	1	2. Name and Ad 1800 New	Hampsh:	ire Ave	s-Rinald nue, Sil	i Fune ver Sp	eral Home oring, MD	, Inc. 20904
30 3		23a. Part1. Finter the	ne disea e or co	mplications that o	caused the deat	th. Do not en	er the mode of	dying, such	as cardiac c	r respiratory a	rrest,		Approximate Interval Between
Physician		Immediat Cause (I	Final		ac Arres								Onset and Death
/Medical		resulting in death)	4	Due to	(or as a conseq	uence of):							
Examiner	L	Sequentially list cor	nditions,	D	icular F		ion						
sit sed	ine	if any, leading to im cause. Enter Under Cause (Disease or i	riving		orasaconseq estive Hea		ura						
xecul and	Examiner	that initiated events resulting in death) L		C	(or as a consec						-		
cate be executed physician and the burial-transit	dical			Atria	1 Fibril	lation							
tificate g phy as the	I W				10,012								
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1☐Live I	tcome pf pregn birth 2 □ Feta nant at time of c own	al death 3	Ectopic pregna Other (specify				2	3d. Date of deli Month	ivery Day Year
that the de led by the a detached f		Part II. Other signif	icant conditions	contributing to d	eath but not res	sulting in the u	nderlying cause	given in Pa	ırt I.	23e. Did 1	tobacco u	se contribute to	the cause of death?
uires tha signed I Id be det	d by	Diabet	es Mellit	us						1 🗆	Yes 2	No 3□Pr	obabły 4⊠Unknown
w requir been si should I	Completed									24a. Was	an	24b. Were au	itopsy findings available
The lav	E C			****							ormed?	prior to death? 1 ☐ Yes	completion of cause of
an: tifficat tor, p	BeC	25. Was case refer	red to medical					26. Pla	ace of Death	1 ☐ Yes		11163	2010
nysician: nis certific director,	.0	examiner? 1 ☐ Yes 2	No	Hospital: 1 🖺	Inpatient 2] ER/Outpatie	nt 3□ DOA	Other: 4 🗆	Nursing Ho	me 5 ☐ Resi	idence 6	3 □Other (Spe	cify)
ding Ph J. After th funeral	n: T	27. Manner of Death	h 5 ☐ Pending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time o	f 28c. I	njury at Vork?		28d. Describe	how injur	y occurred	
endii sath. or: A	atic	2 Accident	investigat	ho			M 1	☐ Yes 2					
or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determine	A Zoe. Place	e of injury · At h ing, etc. <i>(Speci</i>	ome, farm, st fy)	eet, factory, offi	ce		28f. Location (City or To	Street and wn, State	d Number or Ru)	ıral Route Number,
pital ours a eral C	2	29a. Certifier	1⊠ Certifying	Physician: To the	a hest of my kni	owledge deat	h occurred at th	e timo, date	and place	and due to the	Called(e)	and manner as	stated
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical			aminer: On the b			vestigation, in n	ny opinion,	death occur				
Vith To 1	Σ	29b. Signature and	title of certifie				29c. Lic	ense numbe				e signed (Mont	h, Day, Year)
30		,	410			00.17	D	D6	50548		June	21, 2007	
		30. Name and addre	•	o completed caus 15225 Sha				kville	, Maryl	and 208	50		
Sta		31. Date filed (Mon	th, Day, Year)	32. F	agistrar's Sign	ature		1116	,у1	200			
Registi	rar		JUL 2	2007	Corn.	H. A	months.						

The law requires that the death certificate be executed or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

21215-0036

Maryland

Baltimore,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey C. Brown, M.D.

29c. License number D42597

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

7-10-07

26840 Point Lookout Road, Leonardtown, MD

31. Date filed (Month, Day, Year) 1 1 2007

29b. Signature and title of certifier

29a. Certifier

Medical

32. Registrar's Signature

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene									
		For State	State of Ma	arylan					0000	00007
			ast)			Timeate or	Death	2. Date of Dea	nth	3. Time of Death
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Maryland f show ed at	o	10a. State 10b. County	gomery	10c. City						1
r 28a-	irect	10e. Street and Number		<u> </u>		10f. Zip Code			10g. Citizen of What Co	ountry?
ath with	ral D	18113 Hayloft Di	rive							
urs after des al'', or items Examiner m	by	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give					pecify Yes or No- p Rican, etc.)	Black, Whi	te, etc.
n 72 ho "natur edicai B	oleted	(Specify only highest g	rade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	oation during most of work d)	king	16b. Kind of Business	/Industry
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d Men marke matic	ဥ				19h Mailir	nn Address (Street				Zin Code)
and 2 sealth an 27 is i		·								
ages 1 and of He		1 ☐ Burial 2 ☑ Cremation 3		C	emetery, cre	matory or other pla	ce)		•	
mit. P. sartme sortani r injury				Me			ii			
Deg any		Murief &	Bar.	her						20882
Physician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each lii a. Pn Q	ne. La Veg	nia	ter the mode of dylr	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Examiner				a consequ	derice oi).					
sit ad	iner	if any, leading to immediate cause. Enter Underlying		a consequ	uence of):					
execute and al-tran	xam	that initiated events	c. Due to (or as	a consequ	uence of):	<u>-</u>				
ate be e			d							
ne death certifica the attending phe hed for use as t	/sician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3		у			
that the part of t	y Ph	Part II. Other significant conditions	_	ut not resu	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
en sigr	ed b	Parkinson's !	>/sease					1 🗆 Y	′es 2□No 3□P	robably 4 onknown
The law ate has b page 2 sl	Complet							autop perfo	sy prior to death?	completion of cause of
ician: certific ector.	Be	examiner?	Hospital:			Oth		th (Check only o	ne)	
Phys er this eral dir	. To		28a. Date of Inju	ıry	28b. Time o	nt 3 DOA	4 Mursing H			ecify)
ath. or: Afte	atior	2 Accident investigati	on	y Year)	Injury					
tal or Atters are all Directored in by the	Certific	determine	d 28e. Place of inj	ury - At ho c. <i>(Specif</i>	ome, farm, str	reet, factory, office		28f. Location (S City or Tow	Street and Number or Fi vn, State)	lural Route Number,
e Hospi 24 hour e Funer letely fill		(Check only 2 Medical Ex	aminer: On the basis o and manner st	f examina ated.	tion and/or in	nvestigation, in my	opinion, death occu	rred at the time,	date and place, and du	e to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	equis			29c. Licens	re number		29d. Date signed (Mon	th, Day, Year)
•		21 . 6	o completed cause of d	leath (Item	123a) (Type,	Print) Po ha	Philip S	o. oln	or ms.	20832
		31. Date filed (Month, Day, Year)	2007 32. Egistr	ar's Signa	ture	berle			/	
			100		- 17	604F-XX-91B				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Year Physician **JESSIE** Ε. GRAY 30, JUNE 0155 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Apr. 22, 1928 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months 1 M 2 79 220-38-1460 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No MD Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country?

U.S.A.

Home

23d. Date of delivery

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

14. Race - American Indian,

Black

Approximate Interval Between Onset and Death

hours

Black, White, etc.

Funeral Director the Maryland show Examiner must be notified Director 28a-f Pages 1 and 2 should be filed within 72 hours after death with itent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23a or :
ury or other traumatic event, the Medical Examiner must be or 14444 Parkvale Road, #5 20853 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No. If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes Ž No Baltimore, Maryland 21215-0036 2 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Alfred H. Moore Carrie B. Chaney ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14444 Parkvale Rd, #5, Rockville,MD 20853 Robert Gray (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or of Burial 2 ☐ Cremation 3 ☐ Removal from State 5/ John Wesley Cem 7/7/07 Clarksburg, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signatur of Funeral Service Licer 246 N. Washington St, Rockville, MD 20850 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner evere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending plane as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 TYes 24a. Was an After this certificate has autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Peath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury 1 Inatural (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 461

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

Day, Yeak

3 2007

			For State Registrar	State of Ma	Ce	rtificate of			Reg. No.	U	40000
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Y <i>e</i> ar	3. Time of Death
	/Media		LUCY MARGARET O			4h City Tayan	a Logation of Dooth	June	29 2 4c. County	007	10:00 PM
	Examir		4a. Facility Name (If not institution, give s Genesis HealthCa		o Dinos		r Location of Death Ston			lbot	Ē
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthday, 97 Yrs.			8. Date of Birti (Month, Day OCT 14	h v Year)		place (State or Foreign ntry) VYORK
			Usual Residence of Decedent					002 21	,		
	unylan show	_	10a. State 10b. County		10c. City, Town or L					1	10d. fnside City Limits 1 ☑ Yes 2 ☐ No
	38a-1	ecto	MD TALBOT		EA	STON 10f. Zip Code			10g. Citizen of V	Affron Court	
	with t	ā	10e. Street and Number 610 DUTCHMANS LAN	TC			601		rog. Onizeri or v	USA	•
	ms 23	Funeral Director		12. Was Decedent 8	Ever in U.S. 13.		dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	- 14. Rac	e - Americ	can Indian,
980	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, Item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event, the Medical Examinations that indiffied at	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo	If Yes, specify Cubin		Rican, etc.)	Specify	ck, White, WH	etc. HITE
9	72 hou	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	pation during most of work	rina	16b. Kind of Bu	usiness/ln	dustry
21215-0036	within 7 ene. than "r	Completed	Efementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retired SALES CLE	d)	9	CLO	THING	ב
d 2	filed v Hygie ther t		17. Father's Name (First, Middle, Last)	U		SKLES CLE	18. Mother's Nam	e (First, Middle,			,
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ms	To Be	MICHAEL MASTRIA	ANO			PHILOM	IENA MAS	TRIANO		
ary	2 shou and N is mai		19a. Informant's Name/Relationship (Ty	ρe, Print)	19b. Mail	ing Address (Street	and Number or Rur	al Route Numbe	er, City or Town,	State, Zip	Code)
	1 and 2 Health tem 27		NATALIE M. CACCIA	A/DAUGHTEI			BACK LANE				
Baltimore,	permit. Pages 1 a Department of Hes Important: if item eny injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	emoval from State	1	matory or other pla	ce)	Date	20c. Location -		
Ħ.	permit. Page Department o Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License				CION CTR 7				LLE, MD
Ba	permi Depa Impo eny ir		N		F	ELLOWS, H	ess of Facility IELFENBEIN	& NEWN	IAM FUNE	RAL I	HOME PA
			23a. Part1. Enter the disease, or compl	ERCE ications that caused	the death. Do not en		RISON ST ng, such as cardiac			01	Approximate Interval Between
	Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each iir	7	much	CAPA				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	ran our	(012)			- /	y cars
	Examiner		Sequentially list conditions,). 							
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a eoneequanea of);						
	tificate be executed g physicien and as the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
68760,	e be (edicai		d							
	rtifical ng phy as th		IF FEMALE:				2000				
O. Box	that the death cert led by the attendin detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetaf death 3	□Ectopic pregnanc □ Other (specify) _	y			te of defive onth	ery Day Year
s, P.O.	res that the signed by th be detache	by Ph	Part II. Other significant conditions con	ntributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use con	inbute to t	the cause of death?
ord	w requires been sign should be	ted	a cufe,	Macries.	Co. c co.	w. op	yeur you	10	Yes 2□No	3 ☐ Prot	bably 4 ∏Unknown
Vital Records,	aw Isb	Completed						24a. Was autop	osv	Were auto prior to co death?	opsy findings available empletion of cause of
a	t en gar							1 ☐ Yes	2□No	1 ☐ Yes	2 No
× ×	Physician: this certific ral director,	9 Be	25. Was case referred to medical examiner? 1 Yes No	fospitaf:	nt 2 □ ER/Outpatie	ot ou	26. Place of Dear		one) dence 6 ⊟Oth	or (Coor	4 .1
on of	After After fune	tlon; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da		of 28c fnju			how injury occur		<u>y)</u>
Division	= 00 €	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (. City or Tox		per or Rura	al Route Number,
	To the Hospital or At within 24 hours efter of To the Funeral Dirac completely filled in by	Medical C	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner sta	of my knowledge, dea examination and/or i	ith occurred at the ti nvestigation, in my	me, date and place, opinion, death occur	, and due to the rred at the time,	cause(s) and made and place,	anner as s and due t	itated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	FR 1	ND	29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
	2	1	30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Type	, Print)		-	7	-	
			ROBERT SANCHER	mo:	508 TOL	EWILD F	TVENOK	LA	JON M	10	21601

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** June 29,2007 2:03am M Hallas Goldie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 11517 Gainsborough Rd Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 07,1930 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 □ M Missouri 357-24-2083 77 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 3a or 28a-f show t be notified at 10a. State 10b, County 1 ☐Yes 2 ☐ No Director MD Potomac Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11517 Gainsborough Rd 20854 United States r than "natural", or items 23a the Medical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify.White Maryland 21215-0036 Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fed Govt Legislative Assistant permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other i any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vasiliki Georgan Charles Terss ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rockville,MD 20852 10703 Kings Riding Way #T-1, Maria E. Hallas/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 7-3-07 Parklawn Mem Park Rockville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility To Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cholangiocarcinoma /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. End underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo 4☐Pregnant et time of death 5 Other (specify) ed by the a detached f 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Diabetes Mellitus, Parkinsons Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician; after death.

within 2 the 2

29a. Certifier

(Check only one)

29b. Signature and title of eertifier

Medical

D21115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 10215 Fernwood Rd, Bethesda, MD 20817 Lee R. Pennington, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL - 3 2007 Registrar Even B. Sparte

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

July 2,2007

Registrar

State

14

mistrar's Signature

911 Russell Ave. Gaithersburg, MD 20879

30. Name and shriss of person who completed cause of death (Item 23a) Type, Print)

John R. Melnick M.D.

3 2007

31. Date file (Month, Day, Year)

JUL

I.T.J-PAUL MAGLORE HEADLEY Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ June 24, 2007 1645 hrs Medical Examiner LIJ-Paul Maglore Headley 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Worcester Assateague Federal Park Assateaque If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** oreign Days Months Hours Director CountryMaryland 11/06/87 215-17-3546 1 XM 2 F 19 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Lanham Prince George Md 23a or 28a-f show notified at once. with the Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 20706 ä 9503 Nordic Drive 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 X Never Married 2X No Yes Black Yes 2 X No specify: Specify: hours after Widowed Divorced f Yes, Give Year marked other than "natural", c event, the Medical Examin<u>er</u> ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 72 School Student 21215-0036 Pages 1 and 2 should be filed within 'nent of Health and Mental Hygiene. 1st 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Conctance Miller Paul Headlev

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Importaut: If item 27 is m injury or other traumatic ₽ Lanham.Maryland 20706 9503 Nordic Dr Paul Headley Father 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/13/07 West Moreland, Jamaica Family Cemetery Donation 5 Other Specify 22. Name and Address of Facility Snead Mortuary Service, P.A. 21. Signature of Funeral Service Licensee 1409 Fairlakes PL Mitchellville, Md 20721 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death a. Drowning Immediate Cause (Final disease taminer Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical g physician a the burial -AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown signed by the l be detached f the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Yes 2 ✓ No 3 Probably 4 Unknown Completed ficate has been s , page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autonsy this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica æ Other examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA Inpatient 2 1 ✓ Yes 28a. Date of Injury FOUND: 28d. Describe how injury occurred 28c. Injury at Work? After 28b. Time of Injury 27. Manner of Death Certification: Subject drowned FOLIND: Natural Yes 2 V No Pending To the Funeral Director: completely filled in by the Jun 24, 2007 1645 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 31st Street, Ocean City, MD determined (Specify) Ocean Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 25, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month Bay, Year) 32. Rastrar's Signature State 200 Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** A Patricia Esperanza Hartman 28 June 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital Olney Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 XF 37 Sept. 2, 1969 Washington, DC 218-08-0155 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County rral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√☐ No Directo Maryland Columbia Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6702 Quiet Hours 21045 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1√2 Yes 2□ No Baltimore, Maryland 21215-0036 Specify: Guatemalan White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pedro Ajvix Torres Esperanza Maria Hernandez ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Maryland 21045 Aaron Ray Hartman/Husband 6702 Quiet Hours, Columbia, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Gate of Heaven Cemetery July 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2007-22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee Francis J. Collins runces

500 University Blvd, W., Silver Spring MD 200
Approximate Interval Between Interval Between Control Death 23a. Part1. Exter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Due to (or a a consequence of . Physician disease or condition resulting in death) /Medical Examiner Due to (as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): O. Box 68760, nding physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ◯ No 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cellulitie autopsy death? 1 ☐ Yes perform 20 No 2 No certificate or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 □Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

State Registrar 29b. Signature and title of certifier

Bannen

Paul

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18111

2007

Year)

Prince

Bygistrar's Signature

29c. License number

MD060335

, Olary, MD

29d. Date signed (Month, Day, Year)

JUNE

28,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last)

	Physicia /Medic		Leonard Robert Hogendorp	June 27,	2007 4:24 a M
Value 1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Holy Cross Hospital	1 3	lontgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Director		215-38-6886	Sept. 18, 19	
	and w		10a. State 10b. County 10c. City, Town of	or Location	10d. Inside City Limits
	sho sho	ō	MD Prince Georges I	anham	1 □ Yes 🍇 No
	he N 28a-f	ect			. Citizen of What Country?
	vith t	ä	10e. Street and Number		
	ath v	ra	6946 Nashville Rd.		USA 14. Race - American Indian,
	tems	Funeral Director		 Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	Black, White, etc.
36	s afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 【□ No If Yes, Give 3 □ 【Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2☐No Specify:	Specify: Asian
215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at		**	Decedent's Usual Occupation 16	ib. Kind of Business/Industry
5	"nat	Completed	(Specify only highest grade completed)	Give kind of work done during most of working life. DO NOT use retired)	,
12	vithir sne. than	Ē	Elementary/Secondary (0-12) College (1-4or 5+)		eligion
121	Hygie	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma	
ano	ntal led of	Be	Jans Hogendorp	 Wilhelmina deCasembroo	
ž	d Me nark natio	ပို		Mailing Address (Street and Number or Rural Route Number, C	
Maryland	12 st h and 7 Is r traur			maining Addition (Direct and Namber of Main Neste Namber)	,,, <u></u> ,,
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amounts: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once.		20a Mathad of Disposition 20b. Place of I	Nashville Rd., Lanham, MD 20706 Disposition (Name of Date 20	Oc. Location - City or Town, State
Baltimore,	ges it of		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery,	, crematory or other place)	
ij	tmer tant:			tan Crematory Jul 2, 2007 Ale	exandria, VA
3al	ermit Pepar npor ny ir		21. Signal re of Funeral Service Licensee	22. Name and Address of Facility Francis J. Coll	ins Funeral Home, Inc.
	a o	_	Tucken total	500 University Blyd W. Silver Sprin	ng. MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one bause on each line.	of enter the mode of dying, such as cardiac or respiratory arres	Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition a Intracerebral hem	orrhage	
	/Medical		resulting in death) Due to (or as a consequence of	f):	
10	Examiner		Sequentially list conditions b. Cerebrovascular A	ccident	
	T #	ner	Sequentially list conditions, if any local control of the control	f):	
	cuter nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of		
o,	the death certificate be executed y the attending physician and ched for use as the burial-transit	Ä	resulting in death) Last Due to (or as a consequence of	f):	
68760,	ate be nysici ne bu	sician/Medical	d		
89	ntifica ng ph as tl	Jed A	IF FEMALE:		1
Box	ch ce endir	Nu.	23b. Was decedent pregnant	3 ☐Ectopic pregnancy	23d. Date of delivery Month Day Year
	ne deal the att	ici.	in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at time of death	5 Other (specify)	Worth Day Teal
0.	it the by th tache	Phys	9 Li Unknown	11	
ري. ح	w requires that th s been signed by t should be detack	by P	Part II. Other significant conditions contributing to death but not resulting in		cco use contribute to the cause of death?
ő	quire n sig uld b			1	s 2 No 3 Probably 4 Unknown
ပ္ပ	law re as bee 2 sho	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
R	9 F 9	Ē		performe	ed? death? No 1 Yes 2 No
or Vital Records,	ician: Th certificate ector, pag	ပို	25. Was case referred to medical	26. Place of Death (Check only one,	**
5		m	examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Out	Othor	
o	Phys	은	27. Manner of Death 28a. Date of Injury 28b. Ti	ime of 28c. Injury at 28d. Describe how	
on	nding lath. r: After e funer	흲	1 X Natural 5 □ Pending (Month, Day Year) In 2 □ Accident investigation	ijury Work? M 1 □ Yes 2 □ No	
Division	0 % 0 =	Certification:	3 Suicide 6 Could not be 28e. Place of injury - At home, far	m, street, factory, office 28f. Location (Stre	eet and Number or Rural Route Number,
5	i or Atter after dea Director	erti	4 Homicide determined building, etc. (Specify)	City or Town,	State)
_	Hospital 4 hours (Funeral tely filled	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and due to the cal	use(s) and manner as stated.
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	Medical	(Check only one) Medical Examine: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of celtifie	29c. License number 29	d. Date signed (Month, Day, Year)
			I (X) XX	D62885 Jun	ne 28, 2007
	8		30. Name and address of person who completed cause of death (Item 23a) (,
		ate	Sonja Wyche, 1500 Forest Glen Rd, Silver St 31. Date filed (Month, Day, Year) 32. Resistrar's Signature	oring, MD 20910	
i de	Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 2007	book,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 8:30 pm lune 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Hebrew Home Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04/22/1925 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F Director 141-32-6775 82 Hungary Usual Residence of Decedent Dermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyaming. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6105 Montrose Road USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Paul Rado Ilona Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3 2 7 7 1 19a. Informant's Name/Relationship (Type. Print) John Hoffman / Son 806 Edgeforest Terrace, Lake Forest ,F1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/28/07 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) King David Mem.Garden 22. Name and Address of Facility 21. Signature of Eur 7482 Lee Hwy. 22042 National Funeral Home, Falls Church, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** VENTRICULAR /Medical Due to (or as a consequence of) Examiner AI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ZHEIMER DEMENTIA 1 Tes 2 No 3 Probably 4 Nunknown EOPOROSIS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) D57284 1801 East Deferson Stre Rockville, mangland 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month,

Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		Cer	tificate of	Death		. No. 2 1 1 7	23096
÷	Physicia	_	1. Decedent's Name (First, Middle, La Robert	ISY	eal			2. Date of Death Month	Day Year	3. Time of Death
)	/Medic Examin	_	4a. Facility Name (If not institution, gir	e street and number)			or Location of Death		4c. County of Dea	th GOMERY
	F		Shady Grove 5. Social Security Number 6.	Adventist E	lospita /rs. last birthday)	If Under 1 Year				thplace (State or Foreign
	Funeral Director			X	3.6	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Apr. 24	,1947 M	aryland
	yland low at		10a. State 10b. County		City, Town or Loc					10d. Inside City Limits
	e Mar ta-f sh tified	Director	MD Montg	omery	Ro	ckville	<u> </u>			1 Yes 2 No
	th with the 23a or 28 st be no		10e. Street and Number 407 McLane C	ourt		10f. Zip Code 2 (850	10g	U.S.A.	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of I f Yes, specify Cub I ☐ Yes 2 No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	te, etc.
21215-0036	hin 72 ho e. In "natui Medical	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occu kind of work done OO NOT use retire	pation during most of wor ed)	king 16		Transp
2	ed with ygiene ier tha t, the I	Com		2 yrs	S	upervis		/Five Added: Add	Montg.	Со
Maryland	should be filed nd Mental Hygi marked other matic event, t	To Be	17. Father's Name (First, Middle, Las Clarence Is				1	ne (First, Middle, Ma prence Bi		
Mary	iges 1 and 2 should to of Health and Men tilf them 27 is marke or other traumatic		19a. Informant's Name/Relationship Pamela H. Lsre					ral Route Number, C		
	es 1 and of Health f Item 27 r other tr		20a. Method of Disposition	20	b. Place of Dispo cemetery, cren				Oc. Location - City or	
<u>=</u>	Pages ment of I ant: If Ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Spec	ify) Memoval from State	etro Fu	neral S	Srv 7/5		ıexandri	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21 Signal 6 of Funeral Service in	Mande	24 kg 2	2.46 N. 1	ess of Facility S Washingt	SNOWDEN . ton St,R	FUNERAL ockville	HOME, P.A. ,MD 20850
			23a. Part1. Enter the disease, of co shock, or heart failure. List on Immediate Cause (Final					or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due t (or as a con		insur	ction			minutes
à	Examiner		Sequentially list conditions.	b. Hype	r tens	100				Geens
	ed sit	nine	Sequentially list conditions, if any, leading to minimaliate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	. ,	ina in I	1			years
o,	rtificate be executed og physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):	11001	1,1662			
68760,	ate be hysicia the bu	Medical		_ d						
Box	s di se	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome pf produced to 1 □ Live birth 2 □ 1 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 ☐	∃Ectopic pregnand ∃Other (specify) _	су		23d. Date of de Month	elivery Day Year
P.0	nat the d by the letache	Phys	9 Unknown Part II. Other significant conditions		resulting in the u	nderlying cause g	iven in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
rds,	- o -	by	Part II. Other Significant conditions		. Toodaining in the an					Probably 4 ∑∰nknown
or Vital Records,	The law requate has been bage 2 should	Completed						24a. Was an autopsy performe	prior to	
ital	sian:	Be C	25. Was case referred to medical examiner?		\$651		26. Place of De	ath (Check only one	, , , , , , , , , , , , , , , , , , , ,	
or V	ding Physician: The h. After this certificate ha funeral director, page	은	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier 28b. Time o	II 3 DOW		dome 5 ☐ Residen		ecify)
on	Attending Physician: r death. ector: After this certific by the funeral director,	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day Yea		Wo	ork? ☐Yes 2☐No	200. Describe nov	injury occurred	
Division	or Atter after deal Director in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine		At home, farm, str pecify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co		Physician: To the best of my aminer: On the basis of exar and manner stated.						
	To the within 2 To the complex	Mec	29b. Signature and title of certifier	and mariner stated.			nse number		d. Date signed (Mor	
	15		delier 82	uens		PE	36979		June 3	30,2007
	10		30. Name and address of person wh	- 1	(Item 23a) (Type,	Print)	\ (:=\\	50 c E	2 01/1/1	15/m2085
	c+	ate	31. Date filed (Month, Day, Year)	32. Registrar's 5	Gignature	ceren	cente	rior. R	2010011	11.435033
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 282007 **Physician** (0 Zaguirre 9000 M navles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AAUC Annapolis If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 579-24-4246 Honduras 01061923 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Edgewater. 1 □Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 3 21037 Ramsu 3729 USA Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 No 1942If(Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 2□ No1942-Specify: IN hite Saltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Honduran à 3 ☐ Widowed 4 ☐ Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Statistician Dept. of the Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carlos Alberto Izaguirre Julia Tosta ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3729 Ramsey Drive Edgewater, MD. 21037 Martha Jo Izaguirre/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 7/3/2007 Edgewater, Maryland of Funeral Service License 22. Name and Address of Facility Geo. P. Kalas Funeral Home 21. Signatu 2973 Solomons Island Rd. Edgewater, Md. 21037 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician EMORRHA disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending properties for use as as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9☐Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate I funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 1 Inpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 ☐ Accident 6 ☐ Could not be 3☐ Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🖟 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

124 State

Registrar

31. Date filed (Month, Day, Year) 0 2 2007 32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PKWY ANNAPOLIS KENT 2001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 22000 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2007 June 1:50 Рм Norma Joan Kirwan 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Annapolis 2508 Bollard Road 8. Date of Birth (Month, Day, Year) Nov.25, 1931 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) Social Security Number 6 Sex Months Days Hours Arkansas 1 □ M 75 432-46-4168 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes XXNo Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21401 2508 Bollard Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ĂXNo If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: White Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teaching Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marion Elizabeth Eastlack Rov Frank Blackmon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Holmleigh, Windmill Hill, Ashill, Ilminster, Somerset, TA199NT, Great Britain Kimberly J. Baldacchino/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2√√ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/28/2007 Baltimore, Maryland Baltimore Crematory 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mike 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) SCM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

death certificate be executed Box 68760, P.O. I Division or Vital Records,

use as the burial-transi and attending physician for been signed by the should be detached cate has certificate director this funeral After death.

Physician

/Medical

Examiner

Funeral

Director

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Certification:

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Registrar

31. Date filed (Month, Day, Year) State JUL 0 2 2007

29b. Signature and title of certifier

30. Name and address of person

3☐ Suicide

29a, Certifier (Check only one)

4 Homicide

6 Could not be determined

who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

32. Pagistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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30. Name and address of person who completed cause of death (Item 23a)	£ 3 £ 8	Me		M				onth, Day,Year)
Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201					11 Penn Street, Baltimore, M	D 21201		
State 31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature Registrar	St Regis	tate tr <u>ar</u>		32. Registrar's Signature	cell			

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Sheldon James Lankford	d State of Maryland / De or State C	partment of Health and I Certificate of Death	Reg. N	lo							
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Mec. Examiner	Sheldon J. Lan	4b. City, Town, or Lo	July 2, 2007	4c. County of Death							
	Facility Name (if not institution, give street and number) Peninsula Regional Medical Center	Salisbury		Wicomico							
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rath with the Maryland items 23a or 28a-f show any last be notified at once.	e. Street and Number 29323 Beartown Rd.	10f. Zip Code 234	07	USA 14. Race - American Indian, Black,							
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Marital Status Never Married 12. Was Decedent Ever Armed Forces? 1 Yes 2	If Yes, specify Cuban, I	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	White, etc. Specify: Black							
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Should Should Tis man To	a. informant's Name/Relationship (Type, Print) Cleopatra Lankford	P.O. Box 213	Mappsville, VA	23407							
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baltin porta	Signature of Funeral Service Licensee	22. Name and Address	Humbles Funeral	Co., Accomac, VA							
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	30. Name and address of person who completed cause of de	eath (Item 23a)	et, Baltimore, MD 21201								
	Donna M. Vincenti, MD Assistant Medic	al Examiner 111 Penn Street	5t, Datumore, WD 21201								
State Registrar	31. Date filed (Month, Day, Year) 2007 32. Rigistrar			34100							
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JUN 2 7 2007

32. gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** June 28,2007 12:05am M Argentina Menendez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Bethesda Manor Care-Bethesda If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ F July 17,1913 93 Spain Director 577-58-2312 Usual Residence of Decedent with the Maryland 10c, City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1, ☐Yes 2 ☐ No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number $3819\frac{1}{2}$ Woodley Rd, N.W. 20016 United States 72 hours after death Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Spanish 3altimore, Maryland 21215-0036 1⊠Yes 2□No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothes Designer permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Segundo Perez Generosa Perez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maria C. Saavedra/Daughter 3819 Woodley Rd, Washington DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery 7-2-07 Washington DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature)of Fundral Service/Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and Due to (or as a consequence of): Box 68760, physician s the buria Physician/Medical attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 9☐Unknown Month Day 5 Other (specify) ed by the a Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes Ž☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy perform 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 | Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? spital or Attending Phours after death.
neral Director: After to filled in by the funers Certification: 1 🖺 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie H0051280 June 28,2007 10

Registrar

State

Anushiravan Dadgar, M.D. 9715 Medical Center Drive, Rockivlle, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

th, Day, Year)

31. Date filed (Month)

after death. To the Funeral Director: completely filled in by the To the Hospital within 24 hours at

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State Registrar

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person

and title of certifier

29a. Certifie

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who completed cause of death (Item 23a) (Type, Print)

15 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 2007 11:15P^M June 28, Frieda Maier /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**□XF Yrs 98 Jan.30, 1909 Montana Director 507-38-0096 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1161 River Bay Road 21409 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Nanny 6 or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fil f Health and Mental H tem 27 is marked ott Be Frederick Maier Christina Schnieder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Lori Ann Stagnaro / Friend 1161 River Bay Road Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 46/30/2007 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Mic 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG-MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the hiria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🕱 No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2**X**] No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Tes 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUNE 29, as

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

31. Date filed (Mont

Year) 2 2007 32. Refistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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WILLIAM MACBETH

Dhysisi		for State Registrar	State of N	/laryland / D	epartmen <i>Certificat</i>			ı Mental H	ygiene Reg. No.	2 A D =	7 2010	
		Decedent's Name (First, Middle	lle, Last)	1 11				2. Date of D		Year	3. Time of Death	
Physici /Medio		William	B. MAC	beth				JUNE	29	2007	9:50AM	
Examir		4a. Facility Name (If not institutio	on, give street and numbe	r)	4b. City,	Town, or Loc		eath	4c.	County of Deat	th	
		HEARTFIELDS	6. Sex 7. /	Age (In yrs. last birt	thdav) If Under		ASTON Under 24 H	rs. 8. Date of E	Pietle	TALBO		
Funeral Director		5. Social Security Number 137–14–7046 Usual Residence of Decedent	1 X M 2□ F		Yrs. Months		lours M		Day, Year) 192	5 MA	thplace (State or Forei puntry) RYLAND	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. County		10c. City, Town	or Location	Г					10d. Inside City Limi 1X Yes 2 ☐ N	
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Mental H	To Be	JOHN S. MACB							ne (First, Middle, Maiden Surname BELLE BENSON		ne)	
and lisma		19a. Informant's Name/Relations			•	•		Rural Route Nurr			·	
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Depar Impor any in once.		21. Signature of Funeral Service	e Licenso	1	FELLOWS	S, HEL	FENBE	IN & NEW	NAM F	UNERAL	HOME PA	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici	an	Decedent's Name (First, Middle, Last)	NEWGE G	MEDA						2. Date of Dea Month	Day	Year	3. Time of Death	
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			13910 Graceham Road	i			4b. City, Town, or Location of Death Thurmont					F	Frederick		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,					1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, Day Aug. 24	h v. Year)	Year) 9. Birthplace (State or Foreign Country)		
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	anylan show	_	10a. State 10b. County		10c. City, T									10d. Inside City Limits	
	the Mi	Director	Maryland , Frederick		Thur	rmont		0-4-				10. 000		1 ☐ Yes 2 ☐ No	
	3a or	10	13910 Graceham Road	l			10f. Zip	1788	}				on of What Cou	untry?	
	ems 2	Funeral	11. Marital Status	2. Was Decedent Armed Forces	Ever in U.S.	13. \	Was Deced	ent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Amer		
36	rs afte	by F.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	No	- 1	1 ☐ Yes 2		Specify:	, , , ,	1110411, 010.7	-	Black, White		
8	within 72 hours after death with the Maryland ane. than "netural", or Items 23e or 28e-f show ta Madisal Examinar must be notified at	ted	15. Decedent's Educa	ition		6a. Deced	lent's Usua	I Occupa	ition			16b. Kind	Wh:		
215	ithin 7 19.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or	5+)	(Give life. L	a kind of work done during most of working DO NOT use retired)						,		
2	iled w Hygier Ther th	S	12 17. Father's Name (First, Middle, Last)			Chemi	cal U	nit			rator e (First, Middle,		. Gove	rnment	
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 fe marked other than "netural", or Items 23e or 28e-f show eny filury or other traumatic event, the Madical Examinat must be notified at once.	To Be	Lewis Myers								Wetzel	Maiden S	umame)		
ary	shou and M mar	-	19a. Informant's Name/Relationship (Type	, Print)	1	9b. Mailin	g Address	(Street a	nd Numbe	r or Rura	al Route Numbe	r, City or T	Гоwп, State, Zi	p Code)	
<u>سُ</u>	and 2 lealth m 27		Clara D. Myers / Wi	fe					Road		nurmont				
50	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Re	moval from State		etery, cren	natory or oti	her place			Date		ition - City or T		
를	nit. Pa artmer ortant Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	10	Blue.					7/6/0			ont, Ma		
ñ	Depa Impo eny I	b b	KultE.	KIR		RO	BERT :	E. D	AILEY	. & S	SON FUNI	ERAL	HOMES,	P.A.	
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that cause cause on each l	d the death. D	o not ente	er the mode	of dying	, such as	cardiac c	or respiratory ari	est,	MD 217	Approximate Interval Between	
3	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Basal Cell Carcinoma with metastases Years								Onset and Death				
ı	Examiner			Due to (or as	a consequenc	ce of):									
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
g carting in death) is c.						0									
3760,	be ex	dical E		Due to (or as	a consequent	se or):									
	tificate ig phy: as the	ledic	d.												
Rox	The law requires that the death certific tie has been signed by the ettending p age 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	. If yes, outcome 1□Live birth	2 Fetal dea		Ectopic pre	gnancy				23	d. Date of deliv	•	
0	he deg	yslcl	1 Yes 2 No	4□Pregnant a 9□ Unknown	t time of death	5 🗆	Other (spe						Month	Day Year	
ت. ت	that the dended by the ended by		Part II. Other significant conditions contr	buting to death b	out not resulting	g in the un	iderlying ca	use givei	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?	
Spic	w requires been sign should be	ed b	Coronary artery disease 1- Yes a Cerebrovascular accident 24a. Was an								es 2	No 3□Pro	bably 4 Unknown		
Vital Records,	law re las be	Completed by	Cereprovasco	lar.	accia	len	+				24a. Was a				
											perfor		death?	2 No	
	ysician: is certifice director. p	o Be	25. Was case referred to medical examiner?	spital: 1 □ Inpatie	ACIED#	0	•=====	0	~		(Check only or				
0	두 두 등	n: To	27. Manner of Death	28a. Date of Inju	ıry 28b	. Time of	3 □ DOA	c. injury Work	4 🗆 Nui		ne 5 Reside 28d. Describe h		Other (Special Course)	fy)	
<u> </u>	uttending death. ctor: After y the funer	catlo	t Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month), Da	y / 6a//	Injury	М		es 2 🗆 N	lo					
UNISION	for Atl after d Direct S in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury · At home, c. <i>(Specify)</i>	farm, stre	et, factory,	office		2	28f. Location (S. City or Town		Number or Run	al Route Number,	
	To the Hospital or Ai within 24 hours after or the Funeral Direct completely filled in by	a C	29a. Certifier 1□ Certifying Physic	ian: To the best	of my knowled	lge, death	occurred at	t the time	e, date and	place, a	and due to the c	ause(s) ar	nd manner as s	stated.	
	the Ho iin 24 the Fu apletel	ledical	(Check only one) Medical Examine	r: On the basis o and manner st	f examination :	and/or inv	estigation, i	n my opi	nion, death	h occurre	ed at the time, d	ate and pl	ace, and due t	o the cause(s)	
	with with con	Σ	29b. Signature and title of certifier	110	Dn	, <u>,</u>	29c.	License	number	7 7	2	9d. Date s	signed (Month,	Day, Year)	
> -	MIX		30. Name and address of person who com	pleted cause of	Leath (Item 33	Z (Tunn	Print)	, 2	/ / /		(101	4 61	200/	
()		Alan Robert	MD	15 W	est	フエ	5	tree	+	Frede	Vil.	K. Mi	2007	
0	Sta	te	31. Date filed (Month, Day, Year) JUL 5 2007		ar's Signature	_				1	,		/	20101	
	Registra	ar	00L - 0 Z007	Dide	w K	do	me								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Month 12:32 p^M Catherine Patricia Nickless July 9, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 20537 Poplar Ridge Road Lexington Park St. Mary s

9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 XF Director 220-42-1945 63 12/16/1943 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show must be notified at 1 □Yes 2 TXNo Directo Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō items 23a 20537 Poplar Ridge Road 20653 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 X Divorced White 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Nelson Edward Dean Catherine Patricia Ridgell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau once. J. Gail Stone/Friend 25605 Loveville Road, Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 07/14/2007 St. Mary's City, MD St. James Cemetery 21. Signature—Funeral Service descrete

22. Name and Address of Facility

Brinsfield Funeral Hor

Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ❷ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1∐ Yes 2 No Il or Attending Physician; after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2 No ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 ☐ Pending investigation Injury 1 Natural within 24 hours after user...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

(Check only one)

James

29b. Signature and title of certifier

Ρ

24035 Three Notch Road, Hollywood, MD M.D. 32. Registrar's Signature

Jarboe, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		y	Ce	rtificate of	Death	···oritar i	Reg. N	.2007	23100
	Dhyaiai		1. Decedent's Name (First, Middle,	Last)					2. Date of Month		ay Year	3. Time of Death
	Physici /Medic		Charles		e	Penic			June	30	2007	5:55 A. [™]
	Examin	er	4a. Facility Name (If not institution,					r Location of Dea	th	4	c. County of Deat	
	enda kani zaja		635 W. Lynfield 5. Social Security Number		o (In vre Is	ast birthday)	Rockv	ille I If Under 24 Hr	8. Date of	Rirth	Montgon	nery hplace (State or Foreign
D	Funeral Director		439–38–0033 Usual Residence of Decedent	1⊠M 2□F	79	V	Months Days	Hours Min		Day, Year	r) Co	MS
	leath with the Maryland ns 23a or 28a-f show must be notified at	_	10a. State 10b. County		10c. City	, Town or Lo	ocation					10d, Inside City Limits 1X Yes 2 □ No
	he Ma 18a-f	Director		gomery	Ro	ckvil				140 0		
	with t		10e. Street and Number				10f. Zip Code				itizen of What Co	•
	eath ns 23 must	Funeral	635 W. Lynfield 11. Marital Status	Drive 12. Was Decedent	Ever in U.S	3. 13.	2085 Was Decedent of H		Specify Yes o		nited St	
21215-0036	d within 72 hours after death with the Maryland giene. rr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		6-	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		rto Rican, etc.)	Black, Whit	
5-0	72 ho natur lical	eted	15. Decedent's (Specify only highest	Education		16a. Dece	edent's Usual Occup	oation during most of w	orkina	16b.	Kind of Business/	Industry
2	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done DO NOT use retire		9			_
2	a filed was Hygier other the		10 17. Father's Name (<i>First, Middle, L</i> .	2061		Scho	ol Bus Dr	iver 18. Mother's Na	ma (First Mic		cial Edu	ication
anc	d be fintal ted of	Be		E. Penick				To. Mother 3 No.	Lois		,	
Maryland	shoulk mark matic	ို	19a. Informant's Name/Relationshi			19b. Maili	ing Address (Street	and Number or F				Zip Code)
E	nd 2 salth all		Sylvia M. Penick	/Wife			. Lynfie			-		
re,	s 1 a of Hez item othe		20a. Method of Disposition		20b. PI		osition (Name of matory or other pla		Date		Location - City or	
altimore,	Page nnt: If		1 Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe				leaven Cer	1	3/2007	Si	lver Spr	ing, MD.
Balti	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, once.		21. Signature of Funeral Service Li	censee		2	2. Name and Addre	ess of Facility D	eVol Fu	inera.	1 Home	
j.	49 = 10 0		23a. Part1. Enter the disease, or c	omplications that cause	the death						rsburg,	MD. 20877 Approximate
	Physician		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each li Esopha	ne.			ng, saon as oaran	ao oi respirato	ry unost,		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as								
	Examiner	ا ا	Sequentially list conditions,	b								
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated experts	Due to (or as	a consequ	ence of):						
	xecut and II-tran	хап	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):						
68760,	rtificate be executed ng physician and as the burial-transit			d								
	tificat g phy as the	Medical										
P.O. Box	death cer e attendir id for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 🗆 Fetal	death 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date of del Month	ivery Day Year
	s than	þ	Part II. Other significant condition	s contributing to death b	ut not resu	iting in the u	underlying cause giv	en in Part I.				the cause of death?
Ö	w require been signature should b	eted							-		1	robably 4 □Unknown
or Vital Records,	The ate h page	Completed							e l	Vas an lutopsy erformed? es 2⊠N	prior to death?	utopsy findings available completion of cause of 2 □ No
Zi.	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:			Ott	26. Place of De				
ō	Phys r this ral dii	. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Inju	iry	28b. Time of	III OLI DON	4 🗆 Nursing			6 □Other (Spe urv occurred	cify)
on	Attending r death. ector: After	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	ıy Year)	Injury		rƙ?]Yes 2 ∐ No		,	,	
Division	I or Attend after death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 28e. Place of in	ury - At ho tc. (Specify		reet, factory, office			on (Street a Town, Sta		ural Route Number,
	pital of		200 Cartifier 15 Cartifying	Physician: To the best	of my know	ulodao dos	th occurred at the ti	imo, data and pla	an and due to	the equest	(a) and manner of	a stated
	To the Hospital or vithin 24 hours after To the Funeral Direction completely filled in b	Medical	29a. Certifier 1 X Certifying (Check only one) 2 Medical E	xaminer: On the basis of and manner st	of examinat	ion and/or in	nvestigation, in my	opinion, death oc	curred at the ti	me, date a	nd place, and du	e to the cause(s)
	To th withir To th comp	ME	29b. Signature and title of certifier	0 - /			29c. Licens				ate signed (Mont	
			1000	19 of			D45	080		Ju	1y 2, 20	007
/	15+1		30. Name and address of person w									
			Dr. Leon C. Hwai				rd Drive	Kockvi	.11e, M	บ 208	50	
	Sta Registr		31. Date filed (Month, Day, Year)	2007	er o digital	4 A	seed)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 0210 27 ROBERT J. PRUITT June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memorial Hespital 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 XM 2□ F Months Hours Min. JAN 16, 81 ARKANSAS 489-26-4022 1926 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30639 CYPRESS MEADOW DR. 21625 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: ò 3 Widowed 4 Divorced WHITE Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the <u>Medical Ingore.</u> 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) GENERAL OVERSEER alth and Mental Hygin 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be JESS F. PRUITT MARY WALKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar 30639 CYPRESS MEADOW DR., CORDOVA, MD 21625 TERYL V. PRIUTT/SON 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUNSET MEMORIAL 7/2/2007 CLEVELAND, TENNESSEE 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee Ostroushi C.F.SP. Joseph M. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician weeks HSPIRATION /Medical (or as a consequence of): Examiner physica Sequentially list conditions, any hadron immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician:

Robert

within 24 hours after death

To the Funeral Director:
completely filled in by the Hospital

6+1VA

Registrar

4 31. Date filed (Month, Day, Year)

JUN 2 7 2007

29b. Signature and title of certifier

29a. Certifier

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 1, Year **Physician** 2007 Quigley Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 15 Stanmore Court Potomac If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 07/22/1923 Months Days Hours Min. 1 ☐ M 2 ☐ F Pennsylvania 184-24-3499 83 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event. 15 Stanmore Court 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Aves 2 No World
If Yes, Give
Year or Dates: War II 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Law Lawyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Laughlin James S. Quigley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Stanmore Court Potomac, MD 20854 Joan Quigley / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gabriel's Cemet. 07/06/2007 Potomac, Maryland d 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Gastric Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contri <u>^</u> Completed 25. Was case referred to medical Be Hos 1 Yes 2 No 2 27. Manner of Death Certification: 1 Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifice To the within 2

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d				Month Day	Year		
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying ca	ause given in Part I.	23e. Did tobacco	use contribute to the cau	se of death?		
				1 ☐ Yes	2∑ No 3☐ Probably	4 □Unknown		
				24a. Was an autopsy performed? 1□ Yes 2☒N		on of cause of		
25. Was case referred to medical			26. Place of Dea	th (Check only one)				
examiner? 1 Yes 2 XNo	examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence							
27. Manner of Death 1 [ŽNatural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, factory	28f. Location (Street City or Town, Sta	and Number or Rural Rout te)	e Number,			
	nysician: To the best of my knominer: On the basis of examination and manner stated.					ause(s)		
29b. Signature and title of certifier	Roh		License number 52008		Date signed (Month, Day,) Ly 2, 2007	(ear)		
30. Name and address of person who	completed cause of death (Iten	n 23a) (Type, Print)						
Gregory P. Prokop	owicz 601 N. C.	aroline St.	Baltimore,	MD 21287				
31. Date filed (Month, Day, Year)	2007 32. Registrar's Signa	the Speeds	,					
		1						

2:00

10d. Inside City Limits

Approximate Interval Between Onset and Death

¥Yes 2□No

P M

State Registrar

Medical

7-04977 eter Edward R	ohev	Please Type or Print in Black Inde State of Maryland / Departr			ible.
cici Edward IV	-	1- For State Certifi	cate of Death		, No. 2007 231
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
ledical Exami		Peter E. Robey	4b. City, Town, or Location of	June 30, 20	0933 hrs 4c. County of Death
		Facility Name (if not institution, give street and number) 2000 Amber Leave Apt. T2	Waldorf	Death	Charles
Funeral		5. Social Security Number 6. Sex 7. Age (in yrs. last b		24Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington, D
Director		213-66-4428 1 _x M ₂ F 53	Yrs. Months Days Hours	Min. March 22,	Country
the control of the fact that t	er wa apre	Usual Residence of Decedent	wn or Location		10d. Inside City Limits
ow any					1 Yes 2 No
Maryland 28a-f show d at once.		Maryland Montgomery 10e. Street and Number	Kensington 10f. Zip Code	109	g. Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once	Direct	9617 Dewmar Lane	20	895	USA
n with ms 23 b. no	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,		14. Race - American Indian, Black, White, etc.
r death or ite	Funeral	1 Yes 2 No	1 Yes 2 X No specify:	-	Specify: White
hours afte	l by	3 Widowed 4 X Divorced of Fys. Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16	a. Decedent's Usual Occupation (Give k		16b. Kind of Business/Industry
5-0036 led within 72 hou Hygiene. other than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT u	se retired)	
0036 within lene. er tha Medic	dmo	5+	Attorney	- (Find Mall)	Legal
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be Co	17. Father's Name (First, Middle, Last) Frank A. Robey		Name (First, Middle, M Healy	alden Surname)
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f she rerammatic event, the Medical Examiner must be notified at once	. B		19b. Mailing Address (Street and Numb		per, City or Town, State, Zip Code)
imore, MD 2 Pages I and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		Stephen B. Robey/Son	301 Lyric Lane, Silver		
ore, slan of Heal Friten	λ_{λ}	1 X Ruriol 2 Cremation 3 Removal from State crem	ce of Disposition (Name of cemetery, natory or other place)	July 5,	20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	U	4 Donation 5 Other Specify:	of Heaven Cemetery	2007	Silver Spring, Maryland
Baltimore, MD permit. Pages I and 2 shu Department of Health and Important: If item 27 is injury or other traumat		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins	Funeral Home	Inc.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do	500 University Blv o not enter the mode of dying, such as ca	rdiac or respiratory arre	st, shock, or heart Approximate Interval
/Medical ≟xaminer	8 8	failure. List only one cause on each line. Immediate Cause (Final disease a. Head Injury			Between Onset and Death
Lammer		or condition resulting in death) Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		1000	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated purpls resulting in death) I set Due to (or as a consequence of):			
executed an and al - transit	Ä	events resulting in death) Last Due to (or as a consequence oi). d			
e exec cian ar rial - t	dical	UNPENDED AMENDED			
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed eath. or: Affort his certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	Totalia	pregnancy	23d. Date of delivery Month Day Year
OX 68' sath certiff attending or use as	iciar	past 12 months? 4 Pregnant at time of death	4	programay	
Bo ne deat the at	hys	1 Yes 2 No 9 Unknown g Unknown	W. In the control of the course of the Do	# 1 23a Did to	bacco use contribute to the cause of death?
P.O.		Part II. Other significant conditions contributing to death but not resu Chronic Alcohol Abuse	Iting in the underlying cause given in Pa		2 ✓ No 3 Probably 4 Unknown
ds, F equires 1 een sign ould be o	Completed by			24a. Was a	
e law re has t	g			autops perfor	med? death?
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical	26.Place of Death		
Vita hysicia this ce	o Be	1 Yes 2 No	R/Outpatient 3 DOA Other		Residence 6 Other: Scene
n of ding Ph	n: T	1 Netural FO(Month, Day, Year) F	3b. Time of Injury 28c. Injury at Work 1 Yes 2 ✓	Fall	now injury occurred
by ect	cati	2 Accident Investigation Jun 30, 2007 0	920 hrs e, farm, street, factory, office building, etc		Street and Number or Rural Route Number, City
Divis Divis Divis Dipin D	Certification:	3 Suicide 6 Could not be determined (Specify) Multi-Family			tate) eave Apt. T2, Waldorf, MD
E 7 7 5		29a, Certifier (Check only, 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and pla	ce, and due to the caus	e(s) and manner as stated.
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated.		curred at the time, date	
	Σ	29b. Signature and title of pertifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 1, 2007
5		30. Name and address of person who completed cause of death (Item 23			
		Jack Titus MD. Deputy Chief Medical Examiner	111 Penn Street, Baltimore, I	MD 21201	
	tate		Cooles		
Regis	3 12-1	THE TOTAL STATE OF ST	The STATE OF THE S		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#2, perMD, 7/3/07, DPS, MCCO Certificate of Death Reg. No. 2. Date of Deathune 1. Decedent's Name (First, Middle, Last) 27,2007 3. Time of Death **Physician** 2138 A ZOBINSON C. J whe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Columbia er 1 Year | If Under 24 Hrs. | Hospital Howard 8. Date of Birth (Month, Day, Year) If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ■ M 2 🖵 F Yrs. Director <u>234-22-6268</u> 1, 1920 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 ☐Yes 2 No Directo Maryland Silver Spring | 10f. Zip Code Montgomery 10e. Street and Number 10g. Citizen of What Country? 111 Marine Terrace 20905 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify SpecifWhite Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jasper Cleaver ۲ Clara Mongold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Robinson/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Spring, MD 20905 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State July Piney Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part Linter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cerebral anoxía disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COVORANY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed Hopertension that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed Hypercholectero/emca 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Shock liver 2 1 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 14 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 1 No ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a the Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

DHMH 17 Rev 1/2001

State

Registrar

Dr. Willi Am

31. Date filed (Month, Day, Year)

JUL

2007

ORIGINAL

Co.

HOWARD

strar's Signature

D0043662 6/27/07

5755 CEDAR LANE, COLUMBIA, MD 21040

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State 22111 Physicia /Medic Examir **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

Division or Vital Records, P.O. Box 68760,

	Registrar				001	inicate	, UI DI	cairi			No. 🛴 🔱	101		1011	17
an al	1. Decedent's Name	1	115E	RE	A				2. Date of Month		Pay 9	Year		Time of Death	
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ø		mattox Re		- (la	for institution and a six	Davi If Under		ville If Under 24 H	re la Data el	Di-M-	Ann	e Ar			
	5. Social Security No. 534-20-4	675	1 M 29 8	e (In yrs. last 1	Yrs.			Hours Mi	n. 8. Date of (Month) 7/23	, Day, Ye /192.	a <i>r)</i> 5	Co	shing shing	(State or Forei gton	gn
	Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	own or Lo	cation							10d In	side City Limi	ts
tor	Maryland	Anne Ar	undel			nvill	.e							□Yes 2X	
irec	10e. Street and Nur	mber		1		10f. Zip (Code			10g.	Citizen of	What Co	untry?		_
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ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Was Decede	ent of Hisp	anic Origin?	(Specify Yes or erto Rican, etc.	No-		ce - Ame		dian,	
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Be Completed by Funeral Director	Elementary/Secon	ndary (0-12)	College (1-4or 5	i+)		nemake					Но	mo.			
ပ္ပ	17. Father's Name (First, Middle, Last	<u>2 years</u>		11011	ешаке		8. Mother's N	ame (First, Mic	idle, Maid					_
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_	19a. Informant's Na								Rural Route Nu						
	Donald A	. Rea/ H	usband						E., Dav						
	20a. Method of Disp		Removal from State	20b. Place ceme	of Dispo etery, cren	sition (Nam natory or oti	e of her place)		Date		. Location				
		5 ☐ Other (Speci		Our :	-	of So			2-07	(est R		•		
	21. Signature of Eu	neral Sepice Lice	nsee						George						
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	shock, or hea	rt failure. List only	one cause on each lin	the death. L	o not ente	er the mode	or aying,	such as card	iac or respirato	ry arrest,			Inter	roximate val Between et and Death	۵
	Immediate Cause (disease or condition resulting in death)		a. Will	UyN	reta	STA	201	ia (dov				6	mont	4
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Jer	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	nditions, mediate	b. Due to (or as	a consequen	ce of):										
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Completed by Physician/Medical Examiner	resulting in death) L	ast	Due to (or as	a consequen	ce of):										
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/Me	IF FEMALE:		23c. If yes, outcome	of pregnancy											
ian,	23b. Was decedent in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3□	Ectopic pre Other (spe	gnancy					ate of del onth	livery Day	Year	
ysic	1 ☐ Yes 2 ₽ 9 ☐ Unknown	No	9□Unknown	time or deati	, 3	Jourier (spe	-city)			_					
y Pł	Part II. Other signif	icant conditions	contributing to death b	ut not resultin	g in the ur	nderlying ca	use given	in Part I.	23e. [oid tobacc	o use con	tribute to	the cau	use of death?	
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ou:	 Manner of Death Matural 	5 Pending	28a. Date of Inju (Month, Day		b. Time of Injury		Bc. Injury a Work?		28d. Descr	ibe how in	njury occur	red			
cati	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b		un. At homo	form ote	M .		es 2 No	20/ 1 1	(0)			-/-		
ertifi	4 Homicide	determined		c. (Specify)	, iaim, sire	eet, ractory,	, onice			n (Street Town, S		er or Hu	ıraı Hou	ite Number,	
aC	29a. Certifier	1 Certifying Pl	hysician; To the best	of my knowled	dge, death	occurred a	at the time	, date and pla	ace, and due to	the cause	e(s) and m	anner as	s stated.		_
Medical Certification: To Be	(Check only one)	2 ☐ Medical Exa	miner: On the basis of and manner sta	examination	and/or in	vestigation,	in my opir	nion, death o	curred at the ti	me, date	and place,	and due	e to the	cause(s)	
≥	29b. Signature and		JAM u	X	W,,	29c.	License n			29d.	Date signe	id (Monti	h, Day,	Year)	
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Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of Marylan	d / Depa	artmei		ealth an		al Hygie	_	23115
	Physici /Medi Examir	al	1. Decedent's Name (First, Middle, Last, Bruce Rems. 4a. Facility Name (If not institution, give	Burg		9.	я	Location of [Mo	te of Death onth	Day Year	7 8:15 A M
	Funeral Director	55 P.	5. Social Security Number 6. Se 220-18-0313				Days	If Under 24	Hrs. 8. Da	te of Birth onth, Day, Y	Wash. 9.1	Arthplace (State or Foreign Country)
	he Meryland 8e-f ehow otified et	ector	MD Washin		y, Town or Lo	11 i a	mspo	rt				10d. Inside City Limits 11 Yes 2 □ No
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1215-0	be filed within stal Hygiene. ed other than "event, the man	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		life.	kind of w DO NOT	ual Occupa ork done di use retired)	uring most o	f working	16	b. Kind of Busine	·
Maryland 21215-0036		To Be C	17. Father's Name (First, Middle, Last) Hiram Rems					18. Mother's	na Yo	ung	o, Maiden Surname)	
	and 2 should salth and Mer n 27 le marke ler traumatic		Ronald Remsburg	(Son)	437	Loft	у Ні			alibu	City or Town, State	0265
Baltimore,	permit. Pages 1 and Depertment of Heall Important: If itam 2 any injury or other once.		20a. Method of Disposition X Burial 2 Cremation 3 4 Donat on 5 Other (Specify)	Removal from State Lu	Place of Dispo emetery, crer thera	n ce	other place emete	ry /		M		own, MD
Bal	Depending the policy of the po	(21 Strature of Fune all Service Licens	NUMBOL	\$	P. (). Bc	x 18	, Mid	dleto	eral Hown, MD	
760,	Physician /Medical Examiner properties of the principle o	Jicai Examiner	2da. Part1. Eyler the disease, or complete shock, of heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a conse	uence of):							Interval Between Onset and Death Commonths Several years Several years
.O. Box 68	that the death certificat hed by the attending phy detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of Month	delivery Day Year
<u>α</u>	The law requires that the tee bas been signed by the base been signed by the bage 2 should be detache		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying	cause give	n in Part I.	2:	3e. Did toba 1 Yes		e to the cause of death? Probably 4 □Unknown
Vital Records,	ician: The law r certificate has be ector, page 2 sh	Completed	25. Was case referred to medical						1[-	prior death	autopsy findings available to completion of cause of ?? 'es 2 \sumbox No
Division of Vil	ding Phys h. After this funeral di	ation; To Be	examiner?	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		28c. Injury Work	r: 4 Nursi	28d. D	Residen	ce 6 Other (S	(pecify)
Divis	Hospitel or Attend 4 hours after death Funerel Director: tely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)				Ci	ty or Town,	State)	Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurre vestigatio	d at the time n, in my op	e, date and p inion, death	place, and du occurred at t	e to the cau he time, date	se(s) and manner e and place, and o	as stated. due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			25	D 47				d. Date signed (Ma) $1.8/07$	onth, Day, Year)
	Sta Regist		30. Name and address of person who co	ompleted cause of death (Iter	y Pe) Van	ia A	ijs J	hyer	tun	NO 21712

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	State of Manyland / Dor		-									
	State of Maryland / Dep	ertificate of Death		0007 00115								
	RegIstrar 1. Decedent's Name (First, Middle, Last)	Timeate of Death	Reg.	No. 3. Time of Death								
ian cal	Josephine Romano		June 30	Day Year 3:56 a M								
ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death								
	Montgomery Hospice-Casey House	Rockville		Montgomery								
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 5.77-36-9539 1 M 2 1 M 2 1 M 2 1 M 2 1 M 2 M 5	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye									
	Usual Residence of Decedent		April 26,	1915 Pennsylvania								
L	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits								
Funeral Director	Maryland Montgomery Silver			1 ☐ Yes 2☐ No								
E E	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?								
eral	15101 Interlachen Drive, #114 11. Marital Status 12. Was Decedent Ever in U.S. 13	20906 3. Was Decedent of Hispanic Origin? (S	necify Yes or No-	USA 14. Race - American Indian,								
F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ★ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.								
ğ	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🔯 No Specify:		Specify: White								
Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given	edent's Usual Occupation ve kind of work done during most of wor . DO NOT use retired)	king 16t	o. Kind of Business/Industry								
ם	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		wn Home								
ပို	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai									
To Be	Pasquale Capobianco	Ca	terina Con	felone								
[F:8	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or Ru	ıral Route Number, C	ity or Town, State, Zip Code)								
		08 Amelung Lane, De		ryland 20855								
4	1 ☑ Burial 2 □ Cremation 3 □ Removal from State	position (Name of ematory or other place)	Date 200	c. Location - City or Town, State								
		Heaven Cemetery	- 1	ilver Spring, Maryland								
		22. Name and Address of Facility Trancis J. Collins										
	23a, Part1, En the disease, or complications that cause the death. Do not e	500 University Blvo enter the mode of dying, such as cardiac										
ı	shock, or hiert failure. List only one cause on each line. Immediate Cause (Final disease or condition			Onset and Death								
	resulting in death) a. Colon Cancer Due to (or as a consequence of):											
L	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
ine	cause Enter Underlying											
Examiner	that initiated events resulting in death) Last C											
<u>a</u>	d											
Completed by Physician/Medic	STEWN F.											
an/h		B □Ectopic pregnancy		23d. Date of delivery Month Day Year								
/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)		Worth Day Tear								
Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?								
d by			1 Tes	2 No 3 Probably 4 ⊠Unknown								
lete			24a. Was an	24b. Were autopsy findings available								
l mo			autopsy performed 1∐ Yes 2 x	prior to completion of cause of death? No 1 □ Yes 2 □ No								
BeC	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)	10103 2010								
2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			e 6x1Other (SpecifyHospice								
in oi	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how i	njury occurred								
icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury At home, farm,		28f. Location (Stree	t and Number or Rural Route Number,								
ertif	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, S	itate)								
Medical Certification:	29a. Certifler (Check only (Check only 2 ☐ Medical Examiner: On the basis of examination and/or											
ledic	one) and manner stated.											
2	29b. Signature and title of certifier	29c. License number		June 30, 2007								
	Mensene William Cu)	000646	/ \									
	30 Name and address of person who completed cause of death (Item 23a) (Typ Genevieve Wroblewski, M.D. 6001	e,Print) Muncaster Mill Roa	ad, Rockvi	lle, MD 20855								
ate	31. Date filed (Month, Day, Year) 32. Polistrar's Signature											
rar	JUL 2 2007 Seem H.	barle										

Regist

07-05256 Charles Snell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 8, 2007 2110 hrs **Medical Examiner** Charles 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Silver Spring 3160 Gracefield Road 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex 5 Social Security Number **Funeral** Foreign New York Hours Months Davs 122-12-6579 June 17, 1921 Director 86 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 X No 28a-f show Silver Spring Marvland Prince George Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 20904-0806 3154 Gracefield Road, Apt. 111 items 23a or 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 Married 1 X Yes Yes 2 X No specify: Spec#hite f Yes, Give Yaar Divorced 4 Widowed If item 27 is marked other than "natural", her tranmatic event, the Medical Examiner WWII δ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed U.S. Dept. of the Interior, t. Pages I and 2 should be filed within 72 h timent of Health and Mental Hygjene. Elementary/Secondary (0-12) College (1-4 or 5+) National Park Service 21215-0036 Historian $5 \pm$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathryn M. Vedder William A. Snell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code ND 20904 0806 19a, Informant's Name/Relationship (Type, Print) MD. t. 111. Silver S 20c. Location - City or Town, State Spring Julie K. Snell/Wife 3154 Gracefield Road 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) July 11. Burial 2 X Cremation 3 Removal from State or other Metropolitan Crematory 2007 Alexandria. Virginia Donation 5 Other Specify: 22 Name and Address of Carllins Funeral Home Inc. 21. Signature of Funeral Service License MD 20901 500 University Blvd. W., Silver Spring. Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician failure. List only one cause on each line. Pulmonary thromboembolism complicating hypertensive Medical atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED physician a #23a,27, perME, g872, 10/4/07 TT requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown detached for g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. No 3 Probably 4 ✔ Unknown þ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? has Yes 2 1 1 certificate re Hospital or Attending Physician; Th n 24 hours after death. re Funeral Director: After this certifica bletely filled in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Residence 6 V Other: Scene Hospital: 1 Nursing Home 5 ER/Outpatient 3 Inpatient 2 1 🗸 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated g 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME July 10, 2007 O.C.M.E. 30. Name and address of person who completed/cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD.

State Registra

31. Date filed (Month, Day, Year)

Registrar's Signature

GUAR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla State of Maryla For State Registrar	nd / Depa <i>Cer</i>	artment of H rtificate of L	lealth and M Death		giene 2 () Reg. No.	07	23	8
г	11.1	7	Decedent's Name (First, Middle, Last)				2. Date of Dea	ıth		3. Time of	Death
	Physicia /Medic	-	Matthew J. Soldano				Month June	27, 20	Year 07	2:05	P. M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County o	Death		
		1	Casey House		Rockv:	ille		Mont	gome	ry	
	Funeral			s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	Y. Year)	9. Birthpla	ace (State o	r Foreign
	Director	ļ	578-36-7494 ¹ \(\overline{\mathbb{M}}\) \(^{2}\) \(^{\overline{\mathbb{F}}}\)	77 Yrs.			Feb. 2	1, 1930		n. D.	C.
	and w	}	Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or Loc	cation				10	d. Inside Cit	ty Limits
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	the N	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	nat Count	n/?	
	with la or				208	E 2				,	
	leath ns 23 mus	Funeral	12914 Grenoble Drive 11. Marital Status 12. Was Decedent Ever in	U.S. 13. V	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	U . S .		n Indian,	
0	hours after death with the Maryland tura!", or items 23a or 28a-f show al Examiner must be notified at	ᆵ	1 □ Never Married 2 Married 1 M Yes, Give		If Yes, specify Cuba	an, Mexican, Puerto	Rićan, etc.)	Black	White, e	tc.	
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ک ک	72 ho natur lical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	ation during most of work	ina	16b. Kind of Bus	iness/Ind	ustry	
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<u>\sq</u>	ould Men arke	၉	Frank Soldano					W			
Mar	2 sh and is m raum		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a						- 0
<u>ح</u> ش	land Health Im 27 Iher t		Diane L. Soldano - Wife 20a. Method of Disposition 20b	12914 . Place of Dispos	Grenoble		Rockvil Date	1e, Mary		2085	3
saitimore,	it of h	. 4	1 █ Burial 2 ☐ Cremation 3 █ Removal from State	cemetery, cren	matory or other place. Mem. Gd:	:e)	1	Falls Ch	•	,	rinia
	t. Partmer		The state of the s							, VILE	SIMIA
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License		Harand Sage 191 Rockv					nd 2(0852
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.							Approximate Interval Bety	e ween
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7	that led by deta	/ Phy	Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contril	oute to the	e cause of d	eath?
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0	nding th. r: Afte e fun	텵	1 X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		K? Yes 2 □ No					
UNISION	Attending I or death. rector: After by the funer	#ica	3 Suicide 6 Could not be 28e. Place of injury - At	home, farm, str	eet, factory, office		28f. Location (S	treet and Numbe	r or Rural	Route Num	ber,
5	al or s afte nt Dir	Certification:	4 Homicide determined building, etc. (Spe	ouy)		Į.	City or Tou	n, State)			
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinand manner stated.								;)
	o the	Mec	29b. Signature and title of certifier		29c. License	e number		29d. Date signed		Day, Year)	
	F S F Ö		Dag 11108	0	D006	4615		6/29/		,	
•	13		30. Name and address of person who completed cause of death (It	em 23a) (Type	Print)						
			Dr. Genevieve Wroblewski	5001 Mur	ncaster R	d. Rockvi	lle, Md	. 20855			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sig	Inature	Cartes						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 2007 5:00 P M Helen S. Schulze /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Copper Ridge Carroll Sykesville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | May 12, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 1 □ M 2X F 055 20 5986 1926 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐Yes 2XNo Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13426 Good Times Ct. 20777 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: 3 → Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Restaurant Franchise 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank G. Sampson Julia Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4230 Buckskin Lake Drive Ellicott City, MD 21042 John F. Schulze/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 7-5-2007 Catonsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral 8 22. Name and Address of Facility M01044 Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 heimer discure 100cms, Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes □ □ No 24a. Was an autopsy 1∐ Yes 2 **X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA

certificate be executed Box 68760 attending physician Physician/Medical as use for Division or Vital Records, P.O. the Completed page 2 certificate Be 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t Certification: Hospital or Attending Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Medical 29a. Certifier

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34849

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1645

Road & Idersburg

July 5, 2007

EG State Registrar

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

within 72

12 should be filed w h and Mental Hygie ' is marked other ti

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked. any Injury or other traumatic ev

Physician

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Examiner

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31. Date filed (Month, Day, Year) JU

32. Redistrar's Signature

To the within 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State	of Maryland	•			Mental Hyg	iene	/3 =9	00100
			1 - State Registrar			Cer	tificate of l	Death		g. No. 🖒 🔱	U/	<u> 2312U</u>
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	/Medic	al	ROY	ELDE		SMITH	# 0% T	Location of Death	June 28,	200 4c. County of		7:53 P. M
	Examin	er	4a. Facility Name (If not institution 5808 Cabbage	Spring R	1							
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la:	st birthday)		If Under 24 Hrs.	8. Date of Birth	Carro	9. Birthpl	ace (State or Foreign
	Director		212-28-7656	1∰M 2□F	76	Yrs.	Months Days	Hours Min.	(Month, Day, AUG. 12	, 1930	Count Mary	
	pu ,	1	Usual Residence of Decedent		100 City	Town or Loc						
	aryla shov	<u></u>	10a. State 10b. County Maryland Car	11							10	d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ect	10e. Street and Number	roll	MC	ount	Airy 10f. Zip Code		10	Og. Citizen of Wh	at Count	
	with Sa or t be r	Funeral Director	5808 Cabbage	e Spring	Rd.		217	71	"			
	ms 2:	nera	11. Marital Status	12. Was Dec	cedent Ever in U.S.	. 13. V	Vas Decedent of H f Yes, specify Cuba		pecify Yes or No-	United 14. Race	- America	
٥	after or ite		1 ☐ Never Married 2 🂢 Marri	ied Armed F ied 1 X Yes If Yes, G	2 □ No		f Yes, specify Cuba ☐ Yes 2 🔀 No	an, Mexican, Puert Specify:	o Rican, etc.)		White, e	
2-003p	ours ral",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or I					-	Specify:		ite
<u>.</u>	"natu	Completed	15. Decedent (Specify only highes	s Education of grade completed)	16a. Deced	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor	king	16b. Kind of Busi	iness/Ind	ustry
7	withir ene. than he Me	ш	Elementary/Secondary (0-12)	College	(1-4or 5+)		penter	"		Constr	ucti	on Co
ט ס	filed Hygi other ent, ti		17. Father's Name (First, Middle,	Last)			1	18. Mother's Nan	ne (First, Middle, M			Jii 60.
land	lid be fental rked ric ev	To Be	Roy		Sn	nith		Carrie			Rowe	
Mary	shous and N		19a. Informant's Name/Relationsl	nip (Type. Print)		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number	City or Town, S	tate, Zip	Code)
≦	and 2 ealth n 27 i		Alberta Smith	/ Wife			Cabbage			t Airy,	MD	21771
OLE O	Jes 1 t of Hi if iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from	20b. Pla cer	ace of Dispos metery, cren	sition (Name of natory or other plac	e)	Date	20c. Location - C	ity or Tov	vn, State
allimor	. Pag tment tant; jury o		4 ☐ Donation 5 ☐ Other (S	pecify)			Mem.Gar					aryland
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatip and Mental Hygiene. Department of Heatip and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	_		Name and Addres	U	auffer F	uneral I	Home	01700
			23a Part Enter the disease or	complications that	caused the death		621 Oposs					21702
			23a. Part! Enter the disease, or shock, or heart failure. List Immediate Cause (Final						or respiratory arre	,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	d	nocarcin (or as a conseque		age IV E	sophagus				
	Examiner					o spir	1e					
, i	7 5	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to	(or se a our evilue	new off;						
	ecute ind trans	Examiner	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		pertensi							
0/00,	cate be executed physician and the burial-transit	E E	resoluting in deputify East		o (or as a conseque cripharal		ılar Dice	250				
00	physi	dical		d	Tipharai	Vasco	ital Disc	asc			-	
Š	certif nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregnan					23d. Date	of deliver	v
ŏ	death atte	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Fetal o gnant at time of dea		Ectopic pregnancy Other (spec <i>ify</i>)	'		Mont		Day Year
Ò	t the by the acher	hys	9 □ Unknown	9LJUnki	nown							
Ų.	es tha gned se det	by P	Part II. Other significant condition	_		-	iderlying cause give	en in Part I.	23e. Did tob	acco use contrib	ute to the	e cause of death?
cords,	equir	ted	Cholelitha	isis, Hyp	erlipiden	nial,			1 □ Ye	es 2 □ No 3	Proba	ably 4 Unknown
5	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed	Depression	ı, Gerd,	Diverticu	ulosis			24a. Was ar	y pri	or to com	sy findings available pletion of cause of
<u> </u>	t The cate h	Con	Diabetes,	Type II,	Hyperkal	lemia			perförr 1∐ Yes		ath?]Yes	2□ No
VII	sician certifi rector	Be	25. Was case referred to medical examiner?	Hoenital			t 3 DOA Othe		th (Check only on			
5	Phys r this ral dii	. To	1 ☐ Yes 2 No 27. Manner of Death		Inpatient 2 E	R/Outpatient 28b. Time of	000011	4 Li Nui Silig Fi	ome 5 Reside)
5	th. :: Afte	tion	1 Natural 5 Pending	g (Mo.	nth, Day Year)	Injury	28c. Injur Worl	k? Yes 2 □ No		in injury coodino	-	
	Atter	ifica	3 Suicide 6 Could r 4 Homicide determ	inod 200. Plac	e of injury - At hom ding, etc. (Specify)	ne, farm, stre	eet, factory, office	-	28f. Location (St.	reet and Number	or Rural	Route Number,
5	tal or s afte al Dir ed in	Certification:	4 Difficitie	Dulk	allig, etc. (<i>Specily)</i>				City or Towr	, Stare)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		(Check only 2 Medical	ng Physician: To the Examiner: On the	basis of examination	ledge, death on and/or inv	occurred at the tir	me, date and place	e, and due to the ca	ause(s) and man ate and place, ar	ner as sta	ated. the cause(s)
	thin 2 the mplet	Medical	one) 29b. Signature, and title of certifier	and ma	nner stated.		29c. License			9d. Date signed		
	F ≥ F 8		VPU 1-1	Koil	11/1/1	(National)		4749		uly 2,		-41/
^	Qu.		30. Name and address of person	who completed car	ise of death (Item 2	23a) (Type. F				ury Z,		
1	K,		A11 D 411	/ 001			Frederic	k, Maryla	and 2170	1		
	Sta	_	31. Date filed (Month, Day, Year)	5 2007 32.	Pigistrar's Signatu	ire	Land o					
	Registr	ar	JUL V	2 COOL	THE !	5 M	1000					

DHMH 17 Rev 1/2001

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 No

25. Was case referred to medical examiner?
1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

27. Manner of Death 1 XNatural 2 ☐ Accident 3 Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be determined

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28h Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number 29d. Date signed (Month, Day, Year) D54749 July 2, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

801 Toll House Ave D-1, Frederick, MD 21701 Allen Reilly, MD

State Registrar

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, f

Be

P

Certification:

Medical

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State of M		artment of He	alth and Ment	al Hygien Reg. N	Z-11:1 /	23123
			Registrar 1. Decedent's Name (First, Middle,	(ast)				ate of Death		3. Time of Death
	Physici		4.4		SCHE	THER	М	onth D	ay Year	8:30 a ^M
	/Media	al	KATHERINE	NICOLE		4b. City, Town, or Lo	ocation of Death		c. County of Deat	
	Examir	er	4a. Facility Name (If not institution,							
			424 Woonsockett 5. Social Security Number		je (In yrs. last birthday)	Silver	If Under 24 Hrs. 9 D.	ate of Birth	ontgomery 9. Birt	hplace (State or Foreign
	Funeral		220-17-8967	1 M 2 XF	22 Yrs.		Hours Min. (A	fonth, Day, Yea	r) Co	untry)
	Director	-	Usual Residence of Decedent	1	22		reb	15, 1985	MI	
	land ow	} -	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	f sh	ŏ	MD Montao	m o 7417	Silver	Enring				1 ☐ Yes 2 🔀 No
	28a	Director	MD Montgo 10e. Street and Number	шегу	DIIVEL ,	10f. Zip Code		10g. (Citizen of What Co	ountry?
	with a or		424 Woonsockett	Lane		20905		US	SA	
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show to Medical Exarta hat matche molified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		panic Origin? (Specify) Mexican, Puerto Rican		14. Race - Ame	
	Iter d	표	1 X Never Married 2 Marrie	Armed Forces	No			, etc.)	Black, Whit	e, etc.
38	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: Wi	nite
21215-0036	2 hou	ted	15. Decedent		16a. Dece	dent's Usual Occupati	ion	16b.	Kind of Business	Industry
15	_ = = ==	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired)	ung most of working			
212	d within jiene. r than "	E O	12	35.1030 (Stude	ent		Ec	ducation	
g	be filed that Hygie of other event, I	0	17. Father's Name (First, Middle, L	.ast)		1	18. Mother's Name (Firs	t, Middle, Maid	en Sumame)	
<u>a</u>	D E D O	To B	David Kent Sc	hettler			Mary Cather	rine Der	nis	
Maryland	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationsh		19b. Mail	ng Address (Street an	nd Number or Rural Rou	ite Number, City	or Town, State,	Zip Code)
	12 7 14		Mary Catherine	Schettler /	Mother 42	4 Woonsocket	t Lane, Silve	r Spring,	MD 20905	
Baltimore,	of Healt item 2		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place)	Date	20c.	Location - City or	Town, State
JU0	9 5 5	1	1 XBurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			ven Cemetery		07 Silv	er String.	MD
Ħ		li	21. Signature of Fyneral Service L				of Facility Francis			
Ba	permit. Departr Imports any Inj		1 (1440	ho De			Blvd W, Silv			
			23a. Part1. Enter the disease, or	complications that cause	d the death. Do not en					Approximate Interval Between
			shock, or heart failure. List of	only one cause outeach	ine.					Onset and Death
	Physician /Medical		disease or condition resulting in death)		CHIOLITIS	OULITE	RANS			12 YEARS
D	Examiner				s a consequence of):	10 11.00	DISEASE			22 YEARS
ш		e	Sequentially list conditions,	b. CITICON Due to (or as	a consequence of):	US ETOST	DISLASE			
	ed sit	ju	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		MARROW	TOTAL CA MALE	715100)			3- YEARS
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Sone to (or as	s a consequence of):	HOHOS CHIE	ACION			
8760,	be exician buria			Acute	LYMAtoBo	ASTIC 15	LIKEMIA			5 YEARS
87	physic the t	dic		d	1. 1 (10 (3)	عول ۱۰۰۰				
9 ×	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcome	e of pregnancy				23d. Date of de	livery
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			Month	Day Year
o.	the g	/sic	1 ☐ Yes 2, ØNo 9 ☐ Unknown	9□ Unknown	it time of death					
<u>0</u>	that the de ed by the detached	Ph	Part II. Other significant condition	ns contributing to death	but not resulting in the	underiving cause giver	n in Part I.	23e. Did tobaco	o use contribute t	o the cause of death?
ŝ	ires tha signed I be dei	by		RIUM A3		NFECTION		1 ☐ Yes	2. No 3 P	robably 4 Unknown
oro	w requir been si should I	ted	, CONSINCTE	CION, AD	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Oth Word o	utaneu findinge available
ec	e law has b	nple						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
of Vital Records,	rig can	Completed by						1□ Yes 2☑		
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	11 - 12-1			26. Place of Death (Ch			
Ž	chysic this or al dire	To	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat			4 Nursing Home			ecify)
п	g tel	:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date of In (Month, D	ay Year) 28b. Time finjury	Work	?	Describe how in	njury occurred	
Ö	endia sath. or: A he fu	ath	2 Accident Investig	gation		M 1 7	es 2□No		141	North Deuts Alumbas
Division	l or Attendi after death. Diractor: A	Certification:	3 Suicide 6 Could a determ	ined 200. Flace of I	njury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		Location (Street City or Town, St		Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific or pietely filled in by the funeral director.								-	
	Hospita 24 hours Funeral etely filled	cal	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the bes Examiner: On the basis	t of my knowledge, dea of examination and/or i	th occurred at the time nvestigation, in my opi	e, date and place, and i inion, death occurred a	due to the cause t the time, date	e(s) and manner a and place, and du	is stated. le to the cause(s)
	he H in 24 he F plete	Medical	one)	and manner s	stated.					
	To the vitnin To the comple	25	29b. Signature and title of certifie			29c. License	_		Date signed (Mor	
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	St	ate	31. Date filed (Month, Day, Year)	2 2007 32. Pois	trar's Signature	P				
	Regis	rar	JUL	G 2001	ever It ,	Joseph A				

State Registrar

2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 Month **Physician** June 27, A^{M} Ethel Jane Springer 9:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harmony Hall Assisted Living Columbia Howard If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Vear) Days 1 □ M 2 X F 90 02/02/1917 **Director** 159-16-8713 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director ٧A Fairfax Alexandria 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or must be r 22303 USA · death v Funeral 5731 Cannon Lane "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stenographer legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Thomas Н. Cobert ပ Katherine Granshaw 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. William Cobert/ Brother 8906 Stonebrook Lane, Columbia, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Arlington Natl. Cem. 7/31/2007 4 Donation 5 Dother (Specify) Arlington, VA permit. 22. Name and Address of Facility 21. Signature of Fur 5308 Backlick Rd. 22151 Demaine Funeral Home, Springfield, VA bircations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCON METAS TATIL UECKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9□Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an 1□ Yes 2X No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) iving 1 Yes 2 No 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending after death.

Director: Aft in by the fur filled in by 24 hours a within 24

10

31. Date filed (Month, Day, State

29a. Certifier

29b. Sigr

(Check only one)

ure and title of cer

JUL

Medical

Drausa MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

LUTTER Ostyes AL Columbia, Muy 11027 egistrar's Signature

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License numbe

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 12:15 A^M 2007 Dorothy Ann Twohig July 05. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 💢 F Director 173-22-7758 05/15/1928 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City, Town or Location 10d Inside City Limits r 28a-f show notified at 1 X Yes 2 □ No Director Maryland Prince George's Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 12517 Millstream Drive 20715 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White <u>\$</u> 3 ☑ Widowed 4 ☐ Divorced Completed the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lith and Mental Hygiene. 27 is marked other than ' r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) County Government Administrative Coordinator 18. Mother's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) Be 2 Charles Graham Snyder Marguerite Martinez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce E. Larrick/ Daughter 12517 Millstream Drive, Bowie, Maryland 20715 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If it any Injury or conce. 4 Donation 5 Other (Specify) Maryland Veterans Cem 07/10/2007 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons MØ1206 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) +160081S **Physician** Minonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the origing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q 1 ☐ Yes 2 ☐ O 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has I rector, page 2 s 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes S ပ 1 Anpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death

Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory filled in by 4 Homicide fractifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 000058297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Amedrandel medial Contr, Annapolis MD 2140/ HOWARD YOUNG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marguerite Amy Tucker 8:32 Ам 2007 Ju₁v /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 □ M 2 🗙 F 216-80-3737 93 Director August 10, 1913 Maryland Usual Residence of Deccdent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2X No St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20636 25530 Vista Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 21⁄2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Joseph Wallace ည Effie Elizabeth Joy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Guyther / Daughter P.O. Box 502 Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location ~ City or Town, State July 13 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Joy Chapel Cemetery Hollywood, Maryland 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensi 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THEOSCIETOTIC CARDIOVASEVIAL **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. nding physician use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 Tyes within 24 hours after death To the Funeral Director, completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

(Check only

31. Date filed (Mon)

29b. Signature and title of certifier

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

gistrar's Signatu

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ASSOCIATES

29c. License number

HOLLIWOOD

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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			State of Maryland / Department of Health 1- State Registrar Certificate of Deat	h and Men	ital Hygie	_	0.7	23130	
	3	9	Decedent's Name (First, Middle, Last)		Date of Death			3. Time of Death	
	Physici		Elizabeth Eggleston Vance		Month June	30,	2007	10:45 A.M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location			4c. Count		10.15 11.	
			Wilson Health Care Center Gaithersbu	ırg		Montgomery			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Und		Date of Birth Month, Day, Yo				
	Director		212-68-2436 1 M 2X F 92 Yrs. Months Days Hours	Nov	v. 10,	1914		York	
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits	
	ehol	ក						1 (2X)Yes 2 □ No	
	the N	Director	Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code		100	. Citizen of	What Cour	210/2	
	with sor				,09		SA	idy:	
	eath	Funerai		Origin? (Specify	Yes or No-		SA. ce - Americ	an Indian.	
10	riter	Fu	Armed Forces? If Yes, specify Cuban, Mexic		ın, etc.)	Bta	ck, White,	etc.	
8	ours a	by	3 ☒ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☒ No Special Year or Dates:	city:		Specil		nite	
21215-0036	i within 72 hours atter death with the Maryland liene. r then "natural", or Items 23a or 28a-1 ehow tre Medical Exemples must be mustled at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during m	most of working	16	b. Kind of B	lusiness/In	dustry	
2	within ene.	nple	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	de de la companya de				
			5+ Homemaker				me		
n n	9 7 5	Be		other's Name (Fir					
3	1 Mer nark	2	Edward J. Eggleston				ake	0-4-1	
Maryland	Pages 1 and 2 should be ment of Health and Mentiant: If item 27 temarked ury or other traumatice		19a. Informant's Name/Relationship (Type, Print) Sarah V. Roman/Daughter 4229 Franklin Stre						
	1 an Heal tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		c. Location			
Baltimore,	ages int of t: Fil		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	- - 7/1/20					
₽	4 E E E .		4 Donation 5 Other (Specify) 21 Superture of Funeral Service Licensee 22. Name and Address of Fac					VIIginia	
Ba	Depa Impo eny i		10 East Deer Pa					D. 20877	
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such				Lg, III	Approximate	
8	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	L 771				Onset and Death	
	/Medical		disease or condition resulting in death) Due to (or as a consequence of);	. /	,			one were	
в	Examiner		Congettiveheari	than	leer	e			
t _i		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U,	,				
	ransi	Examiner	that initiated events C.	Les	edel				
ő	e be executed sicien and e burial-transit		resulting in death) Last Due to (or as a consequence of						
8760	# × #	licai	d						
x 68	death certificat e attending phy id for use as th	Med	IF FEMALE:						
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy				ate of delive onth	ery Day Year	
o.	0 0 0	Physician/M	1 ☐ Yes 2 M No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 ☐ Unknown						
0	The law requires thet the de. Ne has been signed by the a bage 2 should be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I.	23e. Did tobac	co use con	tribute to th	he cause of death?	
Records,	uires sign Id be	d by	Agrettenseen History of		1 🗆 Yes	2 No	3 🗌 Prob	pably 4 Unknown	
50	w requii been s should	iete	chronougarte abustais.	1	24a. Was an	24h	Were auto	psy findings available	
Re	The lav	Completed	10/2140 11 1500 11 11 11	7	autopsy performe	d?	prior to col death?	mpletion of cause of	
Vital		ပိ	25. Was case elerred to medical 26. Pla	lace of Death (Ch	1 Yes 2	No	1 🗌 Yes	2 L No	
>	Physician: this certific ral director,	ToB	examiner?	Nursing Home		e 6 DOt	ner (Specifi	vI	
٥٥	ding Phy h. After thi funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		Describe how			.,	
Division	Attending r death. ector: After by the funer	Certification:	2 Accident investigation M 1 Yes 2	2 🗆 No					
<u>≅</u>	r Attender death rector:	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Location (Stree City or Town, S		ber or Rura	al Route Number.	
	ital o irs aff rel Di								
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only Check only	e and place, and d death occurred at	due to the caus it the time, date	se(s) and m and place.	anner as si and due to	tated. o the cause(s)	
	the the mplet	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number			. Date signe			
	7 Sor ¥it	-							
•	12		14 Robert Burchacker DO4	7/10	([]	CHALL	_ 3(12001	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	+115 11 RW +17148	CKSBI	CIRC	+UZ	1 38877	
S.,	Sta	te	31. Date filed (Month, Day, Year) 32 Jegistrar's Signature			- Y			
1,5	Registr		JUL - 3 2007 Brown & Specie						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 3:49 A M 3 2007 7 Frances Vujaklya /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Italy 79 9/8/1927 Director 175-20-8158 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 No Director PA Beaver Midland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 15059 13C Midland Heights Homes Funeral 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items Black, White, etc. "natural", or iten 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3₺Widowed 4□Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the M and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Anna Presuitti Angelo Mancini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 50530 Sharon Dr., East Liverpool, OH 43920 Kathleen Ellis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 □Removal from State 7/7/07 Beaver, PA Beaver Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 WIlliam St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASC VD EVISTAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page 2 2 **2** No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Cescribe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 24 hours after death Puneral Director: filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06241

BA 10 State

Registrar

31. Date filed (Month, Day, Year)

DOZOTHY

30. Name and address of verson who come eted cause of death (Item 23a) (Type, Print)



203 SNOW ST, SNOW HILL, MD. 21763

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31. Date filed (Month, Day, Year)

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egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Daniel Frank Wallingsford State of Maryland / Department of Health and Mental Hygiene 2007 23134 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day July 12, 2007 0844 hrs Medical Examiner DANIEL FRANK WALLINGSFORD 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 7635 Carol Road Port Tobacco Charles If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Foreign Months Days Hours Director 579-42-0446 70 7-23-1936 1 X M 2 F WAST D.C Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2X No MD. CHARLES PORT TOBACCO or 28a-f show notified at once. Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 7635 CAROL ROAD 20677 U.S.A. 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. Armed Forces? items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married MARINES 9 If Yes, Give Year KOREA Yes 2 X No specify: Divorced Specify: WHITE "natural", þ permit Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matura injury or other tranmatic event, the Mediteal Examin 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** 5+ COLLEGE OWNER COMPUTER SER.BUREAU SELF-EMPLOYED 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) DANIEL T. WALLINGSFORD FRANCES V.GOLDSBOROUGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE WALLINGSFORD-SPOUSE 7635 CAROL RD. PORT TOBACCO, MD. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) Burial 2 X Cremation 3 Removal from State METROPOLITAN CREMATORY 7-18-07 ALEX., VA. Other Specify: Donation 5 21. Signature of Funeral Service Lice . Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interva Physician Between Onset and /Medical Death a. Ethanol and Temazepam intoxication Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical g physician a the burial -X UNPENDED .28a-f. perME.g870, 8/9/07 TI Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy attending p or use as th 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed has been s 24a Wasan 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No page 1 🗸 Yes 2 Nο the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital æ Hospital: Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient After this 1 Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Natural 1 Yes 2 X No filled in by the fi 5 Pending within 24 hours after death.

To the Funeral Director: Fnd 7/11/2007 | Fnd 8:00 am 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide or Town, State determined (Specify) found at home Carol Road Port Tobacco, MD 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 13, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Ranstrar's Signature 31. Date filed (Month, Day, Year) State Registra

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

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			State of Maryland / Dep		Mental Hygier	ne	
			Registrar	rtificate of Death	Reg. I		i.
	Physici	an	1. Decedent's Name (First, Middle, Last) James Anthony Wilk		Month	Day Year 2007 4:23 P M	
ų.	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	_
	Examin	er	14421 Baskingstove Lane	Silver Spring		Montgomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthplace (State or Foreign Country)	
	Director		216-08-6123 1⊠M 2□F 22 Yrs.	Month's Days Hours Willi.	April 20,	1985 Maryland	
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits	
	fanyla sho ed at	or	Tob. Godiny			1 □Yes 2 □ No	
	the N 28a-1 notifie	Director	Maryland Montgomery Silve 10e. Street and Number	r Spring 10f. Zip Code	10a.	Citizen of What Country?	_
	3a or		1362 Windmill Lane	20905		•	
	ms 2	Funeral		Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,	_
٥	be filed within 72 hours after death with the Maryland that Hygiene. 3d other than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at		Armed Forces? 1 Never Married 2 Married I Yes 2 No If Yes, GlyX	1 Yes XXNo Specify:	o Alcan, etc.)	Black, White, etc. SpecifyWhite	
-0036	ural", I Exa	d by	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:	000-0000-0000	100.00		
<u>7</u>	"nati	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king	. Kind of Business/Industry	
7	withir ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)			Food Commiss	
D N	e filed within 7 al Hygiene. I other than "r vent, the Med	ပိ	17. Father's Name (First, Middle, Last)	Restaurant Worker 18. Mother's Nam	ne (First, Middle, Maid	Food Service den Surname)	_
a	2 should be f n and Mental H is marked ot raumatic ever	o Be	Damian Alexis Wilk	Clair	e Maria Fi	tzGerald	
a <	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Ru	ral Route Number, Cit	ty or Town, State, Zip Code)	_
, Ma	and 2 saith a n 27 is			Windmill Lane, Si	lver Sprin	g, MD 20905	
ore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev		20a. Method of Disposition 1	osition (Name of ematory or other place) Ju		Location - City or Town, State	
Baitimo	. Pag tment tant:	. 35	4□Donation 5□Other (Specify) Gate of H	eaven Cemetery	2007 si	lver Spring, Maryland	3
n n	permit Depar Mpor Iny in			22 Name and Address of Facility. Tancis J. Collins			
		1.0	23a. Part 1. Emer the disease, or complications that caused the death. Do not en			ver Spring, MD 20901	_
	- 1 The state of t	-	shock, or Neart failure. List only one cause on each line.	nor the mode of a jung, out in at our disc	or respiratory arrest,	Approximate Interval Between Onset and Death	
)	Physician /Medical		disease or condition resulting in death) Asphyxiation Due to (or as a consequence of):				_
	Examiner						
¥,		ner	Sequentially list conditions, if any, leading to immediate cause. Finer Underlying. Due to (or as a consequence of):				
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Ç,	oe exe cian a ourial-	E	resulting in death) Last Due to (or as a consequence of):				
00/20	icate be executed physician and s the burial-transit	dical	d				-
X	certifi nding use as		IF FEMALE: 23b. We deceded prognent 23c. If yes, outcome pf pregnancy			23d. Date of delivery	
POX	ne law requires that the death certific has been signed by the attending p ge 2 should be detached for use as	Physician/Me	1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year	
į.	t the cay the achec	hysi	9 ☐ Unknown				_
S,	ss tha gned I	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?	
ecords	equire en si				1 🗆 Yes	2 No 3 Probably 4 Unknown	
ပ္	as be	ple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
_	The cate h	Completed			performed 1□ Yes 2□		
) [ician sertifi ector	Be	25. Was case referred to medical examiner? Hospital: Hospital: 4 Dispersion of DED/Outpetit	Othor	th (Check only one)	· · · · · · · · · · · · · · · · · · ·	_
Ö	Phys this ral dir	₽	1 ★ Yes 2 No No No No No No No No	THE SELECTION ALL NURSING H	ome 5 Residence	e 6 Dother (Specify)Secondary	_
SION	ding h. After fune	lion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation June 27, 2007 4:23	Work?		Residence	
S	Atten deat octor	fica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, s		suicide by 1 28f. Location (Street	nanging t and Number or Rural Route Number, tate)	
5	al or safter	Certification	at home		14421 Baskin	gstove Lane, Silver Sprin	ıg
	To the Hospital or Attending Physician: The I within Exh hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check ohly) 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check ohly) 2 ☑ Medical Examiner: On the basis of examination and/or i	th occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.	
	the H iin 24 the Fi	Medical	one) and manner stated.				_
	Vit To	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)	
)	5			015136		alm lod	_
			30. Name and address of person who completed cause of death (Item 23a) (Type Carl I. Margolis, M.D 11125 Rockvi	Print) 11e Pike, Rockvill	Le, MD 208	52	
	Sta	te.	31. Date filed (Month. Day, Year) _ 32. Restrar's Signature		, 200		_
	Registr		JUL - 3 2007 Klave K	houte i			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Helen Marie Walsh June 28 P^{M} 2007 2:44 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 M 2 👿 F 79 142-22-0988 22,1928 April New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19810 Madrigal Drive 20876 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify White Specify: 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Lott Nora Garvev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy E. Walsh / Son 3192 River Valley Chase, West Friendship MD 21794 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Gábriels Potomac , MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linens, e 22. Name and Address of Facility DeVol Funeral Home, 10 East RACI Deer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute disease or condition resulting in death) MYOCONdial minute Due to (or as a consequence of) ALLOSCHOTOC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

"natural",

other than "natu vent, the Medical

traumatic event,

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Health an

Pages 1 ment of H

Department of Health Important: If item 27 any injury or other ti

72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

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Division

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Director

Funeral

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Completed

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Examine Physician/Medical þ Completed Be

as the burial-transi and iding physician atten signed by the a d be detached for has page 2 certificate director this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral or Certification:

29a, Certifier

Ž**∏** No 1 ☐ Yes 27. Manner of Death 5 Pending investigation Natural 2 Accident 6 ☐ Could not be 3 Suicide

determined 4 ☐ Homicide

Hospital: 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year)

28b. Time of

2 ER/Outpatient 3 □ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury at Work? 1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Wenk, M,D, 9901 Medical Center Drive, Rockville, MD 20850

State Registrar 31. Date filed (Month, Day, Year) 3 2007 32. Pogistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Eulalie Constantine Willis 29, June 2007 1:32 р 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🕱 F Yrs. 579-40-2433 81 Sept. 17, 1925 Trinidad Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11613 Kemp Mill Road 20902 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary White House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Raymond Paige Carmen Constantine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Willis/Son 13862 Carter House Way, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State July Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Kentiles 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease, Diabetes Mellitus (Type II) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown

Physician /Medical Examiner

> and burial-tran

attending physician for use as the buria

been signed by the should be detached

has page 2 certificate

funeral director,

Director: /

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death.

after

To the Hospital within 24 hours at To the Funeral D

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Certification:

Medical

State

Registrar

that the death certificate be executed

Box 68760,

P.O.

Records,

or Vital

Division

Physician

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Funeral

Director

'natural", or items 23a or dical Examiner must be r

the Medical

al Hygiene.

permit. Pages 1 and 2 should be filled v
Department of Health and Mental Hygie
Important: If item 27 is marked other ti
any Injury or other traumatic event, the

with the Maryland r 28a-f show notified at

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

Examine Physician/Medical IF FEMALE: þ Completed

24a. Was an autopsy performe 1∐ Yes 2 **X** No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

	25. Was case referred to medical examiner?
	1 ☐ Yes 2 ☑ No
ı	27 Manner of Death

1 XNatural 2 Accident

5 Pending investigation 6 ☐ Could not be

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

(Check only one)

29a. Certifier

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D52261

29d. Date signed (Month, Day, Year) July 2, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1517 Hugo Alan R. Segal, M.D. Circle, Silver Spring, MD 20902

Hospital:

31. Date filed (Month, Day, Year)

32. Begistrar's Signature

- 3 2007

07-04880

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

arcus vveiis		State of Maryland / Department of I		ygierie Reg.	. No. 200	7 2313
Physicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death
ledical Examir		Marcus Wells		Month E June 27, 20		0015 hrs
		,	 City, Town, or Location of Death Annapolis 	1	4c. County of Death Anne Arundel	_
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8 Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director		217-08-6267 1XM 2_F 35 Yrs.	Months Days Hours Min		Foreig	
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
daryland 28a-f show 1 at once.	5	Maryland Anne Arundel Annapoli	S			1 XYes 2 No
Maryl:	Director		10f. Zip Code	10g	. Citizen of What Cou	ntry?
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? If Yes	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
ter de		1 Yes 2 Å No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X No specify:		Specify: Bla	ıck
urs'af tur'al' amine	db	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	S Usual Occupation (Give kind of		16b. Kind of Business/	
5-0036 led within 72 hours afte Hygiene. other than "natural".	mpleted	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use ret	tired)	_	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	E		Mover		Burnett	Moving
filed Hyging of oth	S	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
21215 uld be fill Mental H marked c event, t	To B	Matthew A. Wells Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A. Marie (Type, Print)	Marsna Address (Street and Number or	Rural Route Numb	er, City or Town, State	e, Zip Code) .
MD d 2 shoth and n 27 is aumatic		Juanita Price(Grandmother) 1 Car	ver St. Annar	oolis, N	1d. 21401	
e, land 1 and Healt litem	ı	20a. Method of Disposition 20b Place of Dispositi	on (Name of cemetery,	Date	20c. Location - City or	Town, State
imore, MD 2 Pages 1 and 2 shoul ment of Health and N rant: If item 27 is n or other traumatic		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Memorial		3-07	Annapoli	s, Md.
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the <u>Medical</u>			me and energy of Facility Son	ns Morti	uary, P.A	
			1 West St. Ar			
Physician - Wedica		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
caminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot wound to neck Due to (or as a consequence of):				Death
		b				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
	Examiner	Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				-
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ox 68760, eath certificate be executed attending physician and for use as the burial - transit	cian/Medical	UNPENDED AMENDED				
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that the detached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		acco use contribute to	
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Vital Rec ysician: The his certificate I director, page	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check			
Physic rthis	P	1 Yes 2 No Inpatient 2 ER/Outpatient		•	Residence 6 Othe	er:
n of \ding Phy h After tl funeral		27. Manner of Death 28a. Date of Injury (Month Day) 28b. Time of Injury (Month Day) 28b. Time of Injury (Month Day) 2330 hrs	jury 28c. Injury at Work? 1 Yes 2 ✓ No	Subject was		
Sior Attend r death ector: by the	cati	2 Accident Investigation 28e Place of Injury At home farm street		28f. Location (St	reet and Number or R	ural Route Number, City
Divis pital or At ours after d teral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify) Outside of townhouse a		or Town, Sta 237 Croll St., A	ate)	,
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifying Physician: To the best of my knowledge, death occurre (Check only)		d due to the cause	(s) and manner as sta	ted.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
F > F 3	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (M	onth, Day, Year)
		hy his, my	O.C.M.E.		June 27, 2007	
B		30. Name and address of person who completed cause of death (Item 23a)	Dolling - MD 04004			
12			t, Baltimore, MD 21201			
St Regist	ate	31. Date filed (Month, Day, Year) JUL 0 2 2007	ande			

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Physici	an/	1- For State Reg. No. 2 3 3 Reg. No. 2 3 3 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Cook has
Medical Exami	ner	Dwayne Warren Warfield 4a. Facility Name (if not institution, give street and number) 1720 Jacob Brunner Drive 4b. City, Town, or Location of Death Frederick 4c. County of Death Frederick
Funeral Director		5. Social Security Number 217-94-0271 6. Sex 1 Age (In yrs. last birthday) 42 Yrs. Months Days Hours Min. Det 17, 1964 Foreign Mary Land
Aaryland 28a-f show any 1 at once.	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Frederick 10c. City, Town or Location 10c. City Limits 10c. City Limits 10c. City Town or Location 10c. City Town or Location 10c. City Limits 10c. City Town or Location 10c. City Town or Location 10c. City Limits 10c. City Town or Location
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	10e. Street and Number 1721 Jacob Brunner Drive 10f. Zip Code 21702 USA
한 등리	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify: Specify: White
7 3 🗇	leted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lor Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
21215-0036 ould be filed within 72 the Mental Hygiene. s marked other than "it event, the Medical.	Completed	1 Technician Medical 17. Father's Name (First, Middle, Last) Warren Warfield 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Grimes
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H, Important: If iten 27 is marked o injury or other traumatic event, th	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Warfield – wife 1720 Jacob Brunner Drive, Frederick, Maryland
Baltimore, Permit. Pages I and Department of Healt Important: If item injury or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Date 20c. Location - City or Town, State 7-5-2007 Frederick, Maryland
	Ş	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 2170
Physician /Medical :aminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death
	iner	Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause Experimentally list conditions, if any, leading to immediate Due to (or as a consequence of): Experimentally list conditions, if any, leading to immediate Due to (or as a consequence of): Experimentally list conditions, if any, leading to immediate Due to (or as a consequence of):
executed an and al-transit	cal Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
60, ate be exc thysician	Medic	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed releath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown
S, P.O. I		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
tal Records cian: The law requi certificate has been a	Completed by	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital I hysician: this certifi	o Be (25. Was case referred to medical examiner? 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Other 4 Nursing Home 5 Residence 6 Other: Scene
ision of A Attending Phy or death. rector: After the	-	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No
ː≥ 유 등 달 ː=	Certification:	Suicide 6 Could not be determined Could not be determined (Specify) Suicide Homicide Could not be determined Could not be determined (Specify) Suicide Homicide Could not be determined Could not be determined (Specify) Salicide Homicide Could not be determined Could not be determined (Specify) Salicide Homicide Could not be determined Could not be determined Could not be determined (Specify)
Di To the Hospital within 24 hours & To the Funeral	Medical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F > F 8	Me	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) June 30, 2007
V		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
S Regis	tate trar	31. Date filed (Month, HallYea) 5 200 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

OCME

1 - For State Registrar Decedent's Nam

Han

31. Date filed (Month, Day,

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

Physician

/Medical

Examiner

Please T	ype or Prin					-		egible.	
For State Registrar	State of Ivia	-	•	cate of		, ,	eg. No./	0007	2211.0
1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
Noel David Wi	lliams					July	1,	2007	9:59 P ^M
a. Facility Name (If not institution, give s		-	4b.		r Location of Death		4c. (County of Death	
Frederick Memoria Social Security Number 6. Sex		L (In yrs. last birti	hdou) If I	Jnder 1 Year	ederick	8. Date of Birth			rederick
	M 2□F			nths Days	Hours Min.	Jan. 2	. Year)	Coui	place (State or Foreign ortry) cyland
0a. State 10b. County		10c. City, Town	or Locatio	n				1	10d. Inside City Limits
Maryland Freder	ick	Br	unswi	ck					1. Yes 2 □ No
0e. Street and Number			10	of. Zip Code		1	_	en of What Cour	
114 4th Ave.					1716			ited Sta	
Ti Maritai Otatao	Was Decedent E Armed Forces?		13. Was	Decedent of I s, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	1	 Race - Americ Black, White, 	
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	1942-	101	∕es 2⊠No	Specify:			Specify:	White
15. Decedent's Educ	eation completed)		(Give kind	s Usual Occup of work done	during most of worl	kina	16b. Kin	d of Business/In	dustry
Elementary/Secondary (0-12)	College (1-4or 5-	-)	life. DO N Engin	IOT use retire	d)			Rai	1road
17. Father's Name (First, Middle, Last)			1.18111	L	18. Mother's Nam	ne (First, Middle.	Maiden S		Livau
William H. Wi	11iams				1	le Koogle			
19a. Informant's Name/Relationship (Typ	e. Print)	19b.	Mailing Ac	Idress (Street	and Number or Ru	ral Route Numbe	r, City or	Town, State, Zip	Code)
Loraine Willia	ms / Wife		11	4 4th	Ave., Bru	ınswick.	MD :	21716	
20a. Method of Disposition		20b. Place of	Disposition					ation - City or To	own, State
1 ☐ Asurial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			le Uni		/2007	Lo	vettsvil	le, Virgin
21. Signature of Funeral Service License	e /		1		ess of Facility Serth Maple	Stauffer			
23a. H. Enter the 1s as or complication of the complete Shock, or heart fail the List only on Immediate Cause (Final disease or condition resulting in death)	Athen	the death. Do n	ot enter the	e mode of dyi		or respiratory arr	est,		Approximate Interval Between Onset and Death
Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last		consequence of	,						
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death		opic pregnanc er <i>(s</i> pec <i>ify)</i> _	у		2	3d. Date of delive	ery Day Year
Part II. Other significant conditions con	00		the underl	ying cause giv	ven in Part I.	23e. Did to	-	se contribute to the	he cause of death?
Diabetes 1	Me//1	+US				24a. Was a autop: perfor	sy	24b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
25. Was case referred to medical					26. Place of Dea	th (Check only or	/		-940
examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatier	nt 2 ER/Out	patient 3	□ DOA Oth	or:	ome 5 ☐ Resid		□Other (Specia	fy)
7. Manner of Death 1 Natural 5 □ Pending investigation	28a. Date of Injur (Month, Day	y 28b. T Year) Ir	njury	28c. Inju Wo		28d. Describe h			· · ·
2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	ry - At home, far (Specify)				28f. Location (S City or Town		l Number or Rura	al Route Number,
29a. Certifier 1. Certifying Physics (Check only one) 2 Medical Examin	ician: To the best oner: On the basis of and manner state	examination and	, death occ	curred at the t gation, in my	ime, date and place opinion, death occu	e, and due to the corred at the time, co	cause(s) date and	and manner as s place, and due t	stated. o the cause(s)
29b. Signature and title of certifier	res MD	DM		29c. Licens	7197	2	29d. Date	signed (Month,	Day, Year)
30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type, Print)/ -	, -				

32. Polistrar's Signature

***0**°5 2007

7th Street Frederick, MD 21701

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Kathleen Eleanor Wilson 15:50PM 0 05 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner B altimor University of Maryland Rehabilitation Center Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) |
September 11,1922 | District of Columbia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 84 577-24-7363 Director Usual Residence of Decedent a or 28a-f show be notified at 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2x No Director Maryland St. Mary's St. Inigoes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17226 Gum Landing Road 20684 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married "natural", or 1 ☐ Yes 2 ☑ No Specify: White 9 Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Business Executive Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth Be Harold Matters UNKNOWN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr William Henry Wilson / Husband 17226 Gum Landing Road St. Inigoes, MD 20684 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia July 7, 2007 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Michael P.O. Box 270, Leonardtown, MD 20650 23a. Part1. Enter the disease or complice if n hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rever /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy for in the past 12 months? Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day) 28b. Time of 27. Manper of Death 28d. Describe how injury occurred After NIA 1 Natural Injury 5 ☐ Pending investigation NIA 1 ☐ Yes 2 ☐ No NIA NIA after death 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di NI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050480 thannes 07/05/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6015, Charles St, Baltimore, 21230 ZERA-YOHANNES 31. Date filed (Month, Day, Year) State JUL 0 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

10c. City, Town or Location

Monrovia

7. Age (In yrs. last birthday)

60

2. Date of Death June 30.

8. Date of Birth (Month, Day, Year)

April

5,

4c. County of Death

10g. Citizen of What Country?

Frederick

2007

1947

USA

12:45 A.M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

New Jersey

		1 - State Registrar				
		1. Decedent's Name	e (First, M	iddle, Las	t)	
Physicia /Medic		Robert	C. Y	oung	, Jr.	
Examin		4a. Facility Name (/	f not institu	ution, give	street and no	umber)
		11795 R	owe F	Road		
Funeral		5. Social Security N	lumber	6. Se		7. Ag
Director		152-38-37	719	15	ZMM 2□F	
 ъ		Usual Residence of	Decedent	t		
ylan iow at		10a. State	10b. Cοι	inty		
a-f sh ified	Director	Maryland	Fr	eder:	ick	
r 28	ire	10e. Street and Nu	mber			
th with		11795 Ro	owe R	oad		
dea	Funeral	11. Marital Status			12. Was Dec	
after or ite	Ш	1 ☐ Never Marr	ied 2∐X	Married	1 ☐¥¥es	2 🗆
ral", c	by	3 ☐ Widowed	4 Divor	ced	If Yes, G Year or I	Dates:
72 h	etec	(Spec	15. Dece	dent's Ed ghest grad	ucation de completed,)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Seco	ndary (0-1	2)	2 College	(1-4or 5
ent,	Be C	17. Father's Name	(First, Mid	dle, Last)		
vid be Menta rked rtic ev	To B	Robert	t You	ng, S	Sr.	
2 short and h is ma auma		19a. Informant's Na				
and salth 27 er tr		Allie You	ing –	wife	=	
oth		20a. Method of Disp				
Page nent c ant; If ury or		1 ဩXBurial 2 4 □ Donation		on 3. □ er (<i>Specify</i>	Removal from)	ı State
permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other than any injury or other traumatic event, the None.		21. Signature of Fu	ineral Serv	ice Licen	see .	2
으 프 프 리		A MAIL	10.1	11 2	m1 1 1 1	/_

Exami

Physician/Medical

Completed by

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

Physician

/Medical Examiner

attending physician and for use as the burial-trar

been signed by the should be detached

page 2 s

this

after death

within 24 hours a

filled in by the funeral

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760.

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐¥Yes 2 ☐ No If Yes, Give Year or Dates:

College (1-4or 5+)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ ¥No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Monrovia

10f. Zip Code

Days

21771

14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry

Assistant Director 18. Mother's Name (First, Middle, Maiden Surname)

Naval Media Center

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11795 Rowe Road, Monrovia, Maryland 21771

Luc 1621 Opossumtown Pike, Frederick, Maryland

Rebecca Cashwell

20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National

Date 20c. Location - City or Town, State 8-28-2007 Arlington, Virginia

Stauffer Funeral Home

23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Metastatic	Liver	Adenocarcinomo
Due to (or as a consequence	of):	
	. #	

22. Name and Address of Facility

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 □ No.

9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 □Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform 1∐ Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

(Check only one)

27. May er of Death 5 Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5 Residence 6 □Other (Specify)

29b. Signature nd title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

EGA 463 31. Date filed (Month, Day,

0

2007

Thomas Johnson Dr Frederich

State

Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year, State Registra

Patricia Aronica-Pollak MD.

32 Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 60 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Meshoth BUTTMOVE Inder 1 Year | If Under MERCY 9. Birthplace 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Months Days 0 Yrs. Man NONE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County maryland 1 Tes 2 X Howard Ellicott Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number oly Woods Drive U.S. 32110 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No lf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFAN7 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woods Drive, Ellicot City, MD HONHMHT 3216 Normandi 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-ASNION FUNERALHOME, Spring 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Tume rematurel disease or condition resulting in death) e to (or as a con equence of): rotem Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown

Priysician /Medical Examiner

Physician

/Medical

Funeral

Director

I Hygiene. other than "natural", or Items 23a or 28a-f show went, its Modical Examiner must be motified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, its Marical Examinary.

attending physician and for use as the burial-transit use as signed by the al Medical Certification: To the Hospins.
within 24 hours after death.
To the Funeral Director: Aft

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certificate

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Completed by Physician/Medical To Be

24a. Was an autopsy performed

1 Yes 2 No 26. Place of Death (Check only or

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 2[] No 1 Tyes

25. Was case referred to medical examiner? 1 ☐ Yes 2 No Inpatient 27. Manner of Death

6 Could not be determined

5 Pendina

28a. Date of Injury (Month, Day Year) investigation

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural 2 ☐ Accident

3 ☐ Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainted at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and itle of control

29d. Date signed (Month, Day, Year)

H0059003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANN NG FAWN T

31. Date filed (Month, Day, Year)

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Physician Pay 2007 Raymond Barth Jr. 12:09AM Arthur /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Pasadena 561 6th Street 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG • 0 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 ☑ M 2 □ F Aug. 212-20-5156 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits la or 28a-f sh 1 ☐ Yes 2 ☑ No Director Pasadena Anne Arundel Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21122 561 6th Street USA permit. Pages 1 and 2 should be filed within 72 hours after death without of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or Items 23a any Injury or other traumatic event, the Medical Examiner must b Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ∏Yes 2 ☐ No If Aes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Regina Cooper Arthur R. Barth Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Evelyn A. Barth (spouse) 561 6th Street, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State July 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 17 Maryland Veterans Cemi Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Stalling Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Physician months mmm /Medical Due to (or as a consequence of) **Examiner** Den Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 **X**No 1 🔲 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 AResidence 6 ☐ Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of D-ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D39505 (Type, Print) HOSpital DV. Glan Bu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 205

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

32 Registrar's Signature

2106

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Crockett 2007 11:42A M Edgar Brewster 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel 11 1st Avenue Glen Burnie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 12/8/1925 1**X** M 2□ F 81 224-28-3990 **Director** Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 X No Glen Burnie Director MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 Funeral 11 1st Avenue IISA or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ white 3 ☐ Widowed 4 X Divorced natural Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Hygiene. Bethlehem Steel Ship Builder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be r and Mental F Francise Brewster Marie Crouse 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Ms. Mary Acton/daughter 11 1st Ave. Glen Burnie MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/2007 MD Veterans Cemetery Crownsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service License 1 Second Avenue SW Glen Burnie, MD 21061 MG1459 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostat **Physician** Jyeurs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury Natural 2 Accident 1 ☐ Yes 2 ☐ No neral Director: A 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENOMO 3001 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 20 4c. County of Death Physician Brown Glenda /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 700 Ga Street, timore Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗙 F 212-36-486 Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No MD altimore Completed by Funeral Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: Blac 3 ☐ Widowed 4 € Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) College (1-4or 5+) er 18. Mother's Name (First, Middle, Maid 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of raci 20c. Location - City or Town, State 20a. Method of Disposition ✓ Burial 2 □ Cremation 3 Removal from State ZiON 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, ML 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ring, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) colon 1150 **Physician** LUNGE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter the origing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, Completed by 4 Unknown 2 No 3 Probably 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No page 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 | Yes 2 | No 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director; completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40654 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Paul Play J1503 Rischers MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Perry Alan Costley 2007 23148 Certificate of Death 1. For State Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ July 17, 2007 Year 0021 hrs PERRY ALAN COSTLEY Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore City** Sinai Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Country) Hours Min. Months Days 18 8/15/1988 Director 218-23-1931 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10b. County in, Gwynn Oak BALTIMORE 1 X Yes 2 No MD Balto. items 23a or 28a-f show ust be notified at once. Director 109. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 USA #2 WALDEN LAUREL COURT 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Examiner must be Armed Forces 1 X Never Married 2 2 X No Yes 9 BLACK 1 Yes 2 X No specify: Snecify: If Yes, Give Year Divorced "natural", δ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) timore, MD 21215-0036

t. Pages I and 2 should be filed within 72 hou trent of Health and Mental Hygiene.

reant: If item 27 is marked other than "na College (1-4 or 5+) Elementary/Secondary (0-12) UNEMPLOYED Comple 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VANESSA COSTLEY MILLER G. WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health and M. Important: If item 27 is m injury or other traumatic #2 WALDEN LAUREL CT, BALTIMORE, MD 21207 Baltimore, MD VANESSA COSTLEY / MOTHER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a, Method of Disposition WOODLAWN CEMETERY 1 X Burial 2 Cremation 3 Removal from State 7/25/07 BALTIMORE CO, MD Other Specify. Donation 5 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Approximate Interval ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart cations that caused the disease, or com Physician Medical Between Onset and wure. List only one cause on each line Death a. Multiple Gunshot Wounds mediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate eause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit certificate be executed Physician/Medical AMENDED 10b,c per fh g869 7-19-07 vt UNPENDED g physician a P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy attending p Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) The law requires that the death 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I signed by the detacher Part II. Other significant conditions Yes 2 No 3 Probably 4 Unknown þ Completed Division of Vital Records, has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be Other₄ Hospital: examiner? Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 1 Yes 2 No 28a. Date of Injury (Month, Day Year Jul 16, 2007 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Subject shot 2357 hrs Yes 2 V No Natural Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 3400 St. Ambrose Avenue, Baltimore City, Md. 3 Suicide determined (Specify) Alley 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 17, 2007 Dincerti, MID O.C.M.E. MU Donna 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD 32 Registrar's Signature 31. Date filed (Month Day Year) State Registrar ORIGINAL

DHMH 17 Rev 1/2001

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AMEND TTEM#18 perFH G869 7/26/07 WS

State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month **EUGENE** CRUMBLEY 130a M /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Taryland Greneral timore (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months 266-28-8738 **X**XM 2□ F Hours GĔŎŔĠIA **Director** Usual Residence of Decedent 10c. City, Town or Location BALTIMORE CITY 10a. State 10b. County 10d. Inside City Limits ir then "natural", or items 23a or 28s-f ehow the Medical Examinar must be notified at N/A Director Y Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2327 N. 21218 USA CHARLES STREET Funerai Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No BLACK þ Specify: Specify: Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then "apportant: other traumatic event, the Me only figure. Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION LABORER 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SARAH CRUMBLEY Hammond EUGENE CRUMBLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Boute Number City or Town, State, Zip Code)

N 10 N. CALVERT ST, BALTIMORE, MD 21201 ARTIE SHAW / LEGAL GUARDIAN 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. CARMEL CEM. 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/20/07 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature TFuneral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AV, BALTIMORE, MD Enter the disease, or complications that caused the hock or heart failure. List only one cause on each line beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical led by the attending p detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. 2 1 No 3 Probably 4 Unknown 1 Tes certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 DNatural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [Homicide ō To the Hospital o within 24 hours aft To the Funeral Di 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nakesh Bassi, M.D. 3. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

9 2007

Amend State of Maryland / Department of Health and Mental Hygiene 2 1 7 7 19 70 7 7 19 70 7 19 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month/ July Year **Physician** Chambers KuTh 2007 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner AUGSBURG LUTHERAN HOME GWYNN OAK BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2ŪF 261-42-3296 Yrs. 74 10/08/1932 Director GEORGIA Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Show traumatic event, the Madical Examiner must be notified at X□ Yes 2□ No MD N/A Director BALTIMORE CITY or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3026 FENDALL ROAD permit. Peges 1 and 2 should be filed within 72 hours efter death w Department of Health end Mental Hygiene. Important: if if item 27 is marked other than "nature" in item 27 is marked other. 21207 Funeral USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: SpecifyBLACK Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry GREATER BALTIMORE Elementary/Secondary (0-12) 1 2 College (1-4or 5+) HOSPITAL TECHNICIAN MEDICAL CENTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM PITMON ALICE MILLS 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3026 FENDALL ROAD, BATTIMORE, ND 212
Date 20c. Location City or Town, State PATRICIA JACKSON / DAUGHTER MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 7/12/07 BALTIMORE CO, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AV, BALTIMORE, disease, or complications that caused the failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner Atherosclerotic Cardiovascular Disease Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physician end for use es the buriel-tren Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probabty 4 Unknown ete hes been signed by page 2 should be detec Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2KINO 1 ☐ Yes 2 ☐ No this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 2√No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After 1 Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No efter deeth.

Director: Aid in by the fu NA investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ö filled in To the Hospital o within 24 hours of To the Funeral Di completely filled is 29a. Certifier tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IXAROLD BOB MO 32. Registrar's Signature Mai 31. Date filed (Month, Day, 9 State Registrar

amend 18 per hosp. g869 7/26/07 KBH Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Į.	For State	State of Maryland	/ Department of H		tal Hygiene	7 23151
Physic	ian	Registrar 1. Decedent's Name (First, Middle, Last)			2. D	ate of Death	3. Time of Death
/Medi Exami Funeral	ner	Makayla 4a. Facility Name (If not institution, give : Clatter 5. Social Security Number 6. Sep	timal l'ed	ica Center	If Under 24 Hrs. 8. D Hours Min.	Month, Day, Year)	Birthplace (State or Foreign Country)
Director		□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	10c City	Town or Location	5 33 30	14 18,800 1 M	10d. Inside City Limits
Maryla a-f shov	ctor	MD		est Hill			1 ☐ Yes 2 ☐ No
with the	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of What	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, it a Medical Evantment to redified at onge.	by Funeral Director	300 Esther Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	21050 13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ☑ No	spanic Origin? (Specify on, Mexican, Puerto Rican Specify:		merican Indian, /hite, etc. Black
21215-0U36 ad within 72 hours afl giene. er than "natural", or than Medical Exerci-	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	furing most of working	16b. Kind of Busine	
d 212 filed with Hygiene. other thai		17. Father's Name (First, Middle, Last)	0	Infant	18. Mother's Name (First	Infant st, Middle, Maiden Sumame)	
Maryland d 2 should be file th and Mental Hy t7 is marked oth traumatic event	To Be	Vincent	Ç	Clark	Yvonne Ar	toinette Clarl	(unknown)
'e, Mary 1 and 2 sho Health and em 27 ls m	17 T	19a. Informant's Name/Relationship (V	nology	19b. Mailing Address (Street a	and Number or Rural Roll	ate Number, City or Town, Stat	e, Zip Code) 2 (204
Baltimore, permit. Pages 1 a Department of Hei Important: If item any injury or othe once.		1 Burial 2 Cremation 3 F	emoval from State	EEN MANT	") uly20,2	007 BALF	Mere, MD
Balt permit. Depart Import any inj		21. Signature of Funeral Service Licens	NATO	22. Name and Address	ORC Pd. MO	nkpn MD	21111
Physician /Medical	ı	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause greach line.	my Distres	g, such as cardiac or res	piratory arrest, Me (Suerl)	Approximate Interval Between Onset and Death
examiner executed in and ial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque Due to (or as a conseque Due to (or as a conseque	vene france of):	atrentig		WHY
Geath certific death certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnand 1□Live birth 2□Fetal of 4□Pregnant at time of dea	death 3 Ectopic pregnancy		23d. Date of Month	delivery Day Year
	by	Part II. Dther significant conditions, con	ntributing to death but not result	ting in the underlying cause give	en in Part I.	23e. Did tobacco use contribut	e to the cause of death?] Probably 4 □Unknown
Y VITAI KECOFY ysician: The law requ is certificate has been director, page 2 should	e Completed	25. Was case referred to medical				autopsy prior deat	
o € € 6	To B	examiner?		R/Outpatient 3 DOA Other 28b. Time of Injury Mort	er: 4 Nursing Home	5 Residence 6 □Other (3 Describe how injury occurred	Specify)
Division (To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office		ocation (Street and Number o City or Town, State)	r Rural Route Number,
Hospital or 24 hours afte Funeral Dire	Medical C		sician: To the best of my know ner: On the basis of examination and manner stated.				
To the within 2 To the complet	Mec	29b. Signature and title of certifier) are to	29c. Licens	onumber 004615B	29d. Date signed (M	onth, Day, Year)
		30. Name and address of person who ca		23a) (Type, Print) 1 N. CHANU	38T. B	7/18 ALTIMOLO, M	POSISQ
S Regis	tate trar	31. Date filed (Month, Day, Year)	Registrar's Signatu	Ire ()			

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, in 24 hours after death.

Reference of the following the full of t

Injury 1 Yes 2 No

6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check o and manner stated. 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rm. 4890, Bultimore, MD Brown M.D31. Date filed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

JUL 19 2007

Medical

Tpletely 1

To the within 2

2 Accident

3 Suicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Edith H. Cashman July 13. 2007 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Social Security Number 7. Age (In yrs. last birthday) Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 103 Months Days Hours 1 □ M 21 F 220-48-7058 Director June 26, 1904 Washington, D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1X Yes 2 No Completed by Funeral Director Chevy Chase Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4617 Drummond Avenue 20815 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Haney Mollie Josephine Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: if Item 27 is
any Injury or other trau Edith Ann Ray/Daughter 6822 Tilden Lane, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 22, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rockville Cemetery Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-350 Inc. 21. Signature of Funeral Service Licensee M00198 23a. Part1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, Examiner cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure use as the burial-trar and Due to (or as a consequence of) the attending physician death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2√ No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 🛛 No 1☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: မ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After Injury 5 Pending investigation 1 X Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D53691 July 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ajay Reddy, M.D. 6320 Democracy Blvd., 6320 Democracy Blvd., Bethesda, Maryland 20817 32. Registrar's Signature State Registrar

CASHMAN, EDITH

			For State	State	of Marylan		artment of H rtificate of I			íene ∍g. NoΩ ∩ ∩	7 001	- I	
			Registrar 1. Decedent's Name (First, Middle	e. Last)			timodio or i	2. Date of Death 3. Time of D					
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	/Medic		4a, Facility Name (If not institution		Ann Conn	er	4h City Town or	Location of Death		1y 17, 2007 4:15PM M			
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	Funeral Director		225-44-4638	1 □ M 2 💢 F		Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Country) Virgini		
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	land ow tt		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside Ci	ty Limits	
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land	ld be enta ked ic ev	To B		John D.	Aker			Myrtle	E. Gorha	am			
<u></u>	shou nd M mar		19a. Informant's Name/Relations			19b. Mailir	ng Address (Street				tate, Zip Code)		
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		Raymond A. Con	mer/ Husl	nand	140	5 Gladsto	ne Drive	. Rockvi	lle. Man	yland 208	51	
ย์	s 1 a f Hez item othe		20a. Method of Disposition		20b. F	Place of Dispo	osition (Name of matory or other place				City or Town, State		
9	age: ent o it: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		n State		Memorial:	i i .11	¹ 2007	Rockwi	lle, Maryl	land	
saltimore,	artme artme ortan injur		21. Signature of Fuperal Service			KIAWII 2	2. Name and Addre	ss of Facility Ro	bert A.	Pumphre	Funeral	Home/	
ğ	Depi Impo any			$\mathcal{I}(\mathcal{L})$	- MOO	225	Rockvill	e, Inc.	300 West	Montgoi	Funeral nery Avenu	.e	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 🕅 Certifyi	ing Physician: To t	he hest of my kn	owledge dea	th occurred at the ti	me, date and plac	e, and due to the o	cause(s) and mai	nner as stated		
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1	9		30. Name and address of person					F-40 d - 4-4 - 1	. Mar1-	nd 2170	2		
			Hemen Shah, M	1.D. 65C	Phomas J Registrar's Sign	onnson	prive, l	rederick	, maryia	mu 21/0	4		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day **Physician** VALESTINE V. COLE-Tindall 2007 July 3:45aM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3812 Beehler Ave Baltimore 8. Date of Birth (Month, Day, Year) DEC.1,1946 7. Age (In yrs. last birthday) ear If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1□ M 2□ F 215 46 6780 MARYLAND 60 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at ¹Ç Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 arent of Health and Mental Hygiene. arent of Health and Mental Hygiene. arent of Health and Zi is marked other than "natural", or items 23a or items ury or other traumatic event, the Medical Examiner must be nuy or other traumatic event, the Medical Examiner must be no 3812 Beehler Ave. 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK þ Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) ENVIRONMENTALTECHNICIAN SCHOOL BOARD OF ED. 11TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CALVIN C. MURRAY PEARL ROY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3812 BEEHLER Ave HEYWARD TINDALL(husband) BALTO, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot Burial 2 □Cremation 3 □Removal from State ARBUTUS MEM.PK. JULY 23,20|07 BALTO,MD. 4 Denation 5 ☐ Other (Specify) gry ture of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 PRESTON ST BALTO MD. e. 21213 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNGCANCER **Physician** NOV 06 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** JUNE 07 SRAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident in by the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗖 🕊 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar 31. Date filed (Month, Day, Year) JUL 19 2007

Gul Ws

(Check only one)

29b. Signature and itle of certifier



MD

packet

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D22652

29d. Date signed (Month, Day, Year)

7/17/07

arbara Downey		For State	of Maryland /		ent of Hea ate of Dea		Mental Hy	giene Reg.	No. 2	007	2315
Physician/	1	Decedent's Name (First, Middle,Las	•		Nau	111=11		2. Date of Death Month D	ay Yea		me of Death 030 hrs
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		1100 Pennsylvania Avenu	•			imore *			<u> </u>	NIA	(0)
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Baltimore, oemit. Pages 1 a Department of He important: If it injury or other t	- 1	1 Burial 2 Cremation 3		are _	tory or other pla		TERM 17-	-20-07	BALT	THORE	E. MA
Baltimor permit. Pages Department of Important: If		Donation 5 Other Specification of Funeral Service Lice		M.	22. Name a	nd Address		ROWN	R. Fr	INERA	1 HOME
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tox 6876 eath certificate eath certificate a attending phy for use as the b	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal de		Ectopic pregna	ancy	Month	Day	Year
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Division of Vital Records, P.O. Box 68761 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the the factor of the control of the detached for the production of the control of the c	ן ש		ician: To the best of ner:On the basis of exa	ny knowledge, di amination and/or	eath occurred a investigation, it	n my opinion,	death occurred	at the time, date a	nd place, and	d due to the ca	ause(s)
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		(lalin	em	doub (It-w 00-		O.C.N	/I.⊑.		July 18, 2		
1		30. Name and address of person wh Laron Locke MD. Assi	o completed cause of stant Medical Ex			eet, Baltim	nore, MD 212	201			
Sta		31. Date filed (Month, Day, Year)	2007	ar's Signature	love	<i>y</i> .					
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			For State Registrar	State of Maryl		artment of F			iene	23157
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4	/Medic		4a. Facility Name (If not institution, gir		ar	4b. City, Town, o	r Location of De	ath	4c. County of Dea	
	Examin	er	Veterans Adminis		al Cen.		ltimore		N/A	
	Funeral		5. Social Security Number 6.	Sex. 7. Age (In	yrs. last birthday		If Under 24 H	n (Month Day	9. Bir	thplace (State or Foreign
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	and *		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or L	ocation				10d. Inside City Limits
	4 within 72 hours after death with the Maryland liene. 1 thm natural', or items 23a or 28a-f show The Madical Examinar must be notified at	to	Maryland Anne A				ilen Bur	nie		1 ☐ Yes 2 ☑ No
	or 28a	Directo	10e. Street and Number			10f. Zip Code	TON DUI		0g. Citizen of What Co	ountry?
	23a c	aiD	404 Eugenia Aver	nue			21061		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whi	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	√hite
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Z	2 should and Men is marke	ř	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street			City or Town, State	Zip Code)
	TENE		Virginia L. Dunca			Eugenia A	Avenue.	Glen Burn	ie. MD 210	61
ore	ges 1 and t of Heelt if Itam 2 or other		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 [Removal from State	b. Place of Disp cemetery, cre	osition (Name of matory or other place		Date	20c. Location - City or	Town, State
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Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature il Foneral Servi a Libe	optiee /	2	2. Name and Addre			gs Funeral dena, MD 2	Home, P.A. 1122
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List on	polications that caused the one cause on each line.	death. Do not er	iter the mode of dyir	ng, such as card	iac or respiratory arre	est,	Approximate Interval Between Onset and Death
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Division	\$ £ 5 €	Certification	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm, soecify)	treet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	lural Route Number,
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	thin 24 thin 24 the F	Medicai	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			9d. Date signed (Mor	
	or with the second		Melibal	i Too soon	Contr	NO PI	19830	9	07/14/	2007
,	1		30. Name and address of person who	o completed cause or death	(Item 23a) (Type	Print)	,00			21201
1		1	Kimberli T	Aylo-ciar	Ke :	22 Sa	th G	eere St	reet BI	ILTIMORE MD
	Sta Registi		31. Date filed Month, Pay (Yea)	7 32. Registrar's S	Signature	e.				f
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** <u>Aniyah Nevaeh Douglas</u> 15 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Baltimore Medical Ιου more If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 07,16,2007 Birthplace (State or Foreign Country) None **Funeral** 1 □ M 2 🗗 F Days Months Hours Min. MD Director 23 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 Yes 2 No Director MD Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 or Itams 23a 2406 Battersea Place #101 21204 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 Tyes 2 No Specify: unknown by Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, It. My Elementary/Secondary (0-12) College (1-4or 5+) 0 0 Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ douglas Takeya Kelly Aniqul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ATHOLOG 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service once 21111. DOVKTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician reterm 23 min /Medical Due to (or as a consequence of): Examiner m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last unknown by Physician/Medicai Examiner (or as a consequence of) Division of Vital Records, P.O. Box 68760, 5 To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 thet use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ĺ Month 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 No 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 Tyes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2**X** No 1 🗌 Yes Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral ate of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. 1 Natural Injury 5 Pending М 2 🗌 No within 24 hours efter death. To the Funerel Director: 1 TYes investigation 2 Accident the th 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kimberly

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiana

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	/Medica Examine		4a Facility Name (/		e street and number)	1	, ,			4b. City, Town, o	r Location of De	ath 4	c. County	of Death		
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	Funeral		5. Social Security N		ex 7.Ag	e (fn yrs.	last birthday) Yrs.	If Und Month	er 1 Year Days	If Under 24 Hr Hours Min	n. (Month,	Day, Yea.			ce (State or	Foreign
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	72 hours after death with the Maryland natural", or fterns 23s or 28s-f show affest Evanifier invest be notified at	ᇛ	4810 Ham:	ilton Ave	nue				2	1206			US	A		
	dea me	runerai	11. Marital Status		12. Was Decedent Armed Forces?		S. 13. V	Vas Dec	edent of H	lispanic Origin? (an, Mexican, Pue	(Specify Yes or erto Rican, etc.)	No-		e - Americar k, White, et		
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lan	ild be lental kad o	0								Philis	hia Rei	d				
Maryland 21215-0020	S E E		19a. Informant's Na	ame/Relationship (Type, Print)		19b. Mailin	g Addre	ss (Street	and Number or I	Rural Route Nur	nber, City	or Town,	State, Zip C	ode)	
Σ	1 and 2 Haalth a om 27 is		Universi	ty of MD	Medical C					Street				1201		
Baltimore,	permit. Pages 1 a Department of Hai Important: If item any injury or othe once.		20a. Method of Disp		Removal from State	20b. P	lace of Dispo- emetery, cren	sition (A	lame of r other plac	сө)	Date	20c.	Location -	City or Tow	1, State	
Ĕ	Pa ji ji ji		4 Donation	5 MOther (Specify	n) in state											
Satt	permit. Pag Department Important: I any Injury o		21. Signature of Fu	neral Service Licer nthony Da	Pleasant		1 22 S	. Name	and Addre	ss of Facility tomy Boa	ard 655	W. B	altim	ore S	treet	
ш	20.5 2 3	İ	Plan	Dames	1 Stee	ma	nt B	alt:	lmore	, MD 21	201					
			23a. Part T. Enter to shock, or hea	ne disease, or com nt failure. List only	plications that caused one cause on each li	the death	n. Do not ente	er the m	ode of dyir	ng, such as cardi	ac or respirator	arrest,		1 1	Approximate interval Betw	/een
	Physician								9'						Onset and D	Balli
2	/Medical Examiner		Immediate Cause (disease or condition resulting in death)	(Final n	. Extren	No 1	stema	AW	rutu							
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68760,	ficate be executed 1 physician and 1s the burial-transit	edicai	Cause (Disease or that initiated events	injury	c	Due to (or	r as a conseq	uence o	n):							
	* DO 65		resulting in death)	Last		,								1		
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of Vital Records,	Physician: rthis certific eral director,	<u> </u>	27. Manner of Deat		Hospital: 1 Hepatie		28b. Time of		28c. Inju	4 LI Nursing	Home 5 ☐ R					
on	ding th. After		1 Natural 2 Accident	5 Pending investigation	(Month, Da	y Year)	Injury	М		rk? ∣Yes 2∐No						
Division	or Attanding after death. Director: After in by the fune	20	3 Suicide	6 Could not be	286. Place of Inj	ury - At ho	ome, farm, str	eet, fact	ory, office			n (Street Town, Sta		er or Rural	Route Numi	ber,
á	afta afta Dir d in t	Certification:	4 ☐ Homicide		building, et	с. (Брөсп)	"				City of	rown, on	110/			
	To the Hospital or Attanding Phywithin 24 hours aftar death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier (Check only	Certifying Ph	ysician: To the best	of my kno	wledge, death	OCCUFFE	ed at the time	me, date and pla	ce, and due to t	he cause	(s) and ma	nner as ste	ted.);
	he He in 24 he Ft	edical	one)	0	and manner st	ated.	and/or in				COLLEGE OF THE THE					
	To the Vithin 2 To the comple	Σ	29b. Signature and	title of certifier	0.0	~			9c. Licens	se number		29d. [1 - 1	d (Month, D	-	
				Lal	M.J				V17*1				1151	200)	
			30. Name and addr	ess of person who	completed cause of d	leath (Iten	23a) (Type,	Print)	2							
			31. Date filed (Mon	th, Day, Year)	32. Registr	WWV	MS.	N	13							
	State Registra		31. Date illed (MOI)	JUL 1 9	2007	Gass.	14	Ara	W.							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** DRUMHEISER 1:28 AM WALTER 2007 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOPKINS JOHNS HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Mar 7, 1938 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Year) Days Hours Min. 1 M 2 □ F 168-30-4659 69 PA Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popartment of Health and Mental Hygiene. In protain: If Item 23a or 28a-f show Important: It fem 27 is marked other than "natural" or Items 23a or 28a-f show any injuny or other traumatic event, the Medical Examiner must be notified at 28a-f show 1 ☐ Yes 2☐ No Director PA Berks S. Heidelberg TWP 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 301 Kappa Court 19565 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married XX Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Lineman Electric Utility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be file of Health and Mental H Be Emerson Drumheiser Marian Eichemberger မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria J. Drumheiser 301 Kappa Ct., Wernersville, PA 19565 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 🗷 Burial 2 □ Cremation 3 □ Removal from State Sinking Spring Cemetery July 20, 2007 Sinking Spring, PA 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Fink Funeral Home, P.A. K. Gregory Kink 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part1. Enter the disease, shock, or heart failure. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nlyone cause on each line. Immediate Chuse (Final **Physician** MYELOID LEUKEMIA HYEARS 8 Months ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transi and P.O. Box 68760_ Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 □ Yes 2 No 3 Probably 4 Unknown cate has been si, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 1 Ho 24a. Was an autopsy performed certificate 2 1 N Attending Physician: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√No 1 Nnpatient ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records,

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

FREDERICK HRISTIAN Registrer's Signature 31. Date filed (Month, Day, Year) JUL 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEYER

401 NORTH BROADWAY

29d. Date signed (Month, Day, Year)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

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			For	State of Ma	aryland.	/ Depa	rtment of H	lealth and N	•	•	
			= State Registrar Amedn #13. p	erInf, G869,	7/30/07	7TTCer	tificate of	Death		g. No.	20161
F	Physicia	an a	Decedent's Name (First, Middle, La	ist)					Date of Death Month	Day Year	3. Time of Death
d)	/Medic	_	Robert H. Edwar			1	4h City Tayan a	r Location of Death		5, 2007 4c. County of Deatl	2:30 PM
90	Examin	er	4a. Facility Name (If not institution, give		± a 1			kville		Montgom	
-	Funeral			Sex 7. Age	e (In yrs. las	t birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth	nplace (State or Foreign untry)
	Director		103-12-5522	522 83 Yrs. September 26, 1923							
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho ied a	tor	Maryland Montgo	omerv		Poto	mac				1 □Yes 2 ☑ No
	or 28a	Directo	10e. Street and Number	<u></u>			10f. Zip Code		10	g. Citizen of What Co	untry?
	23a c ust be		10821 Maplecres				20854			United Sta	
	er dez	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Was Decedent of H f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	Ir, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates: V	WWII		1∭XYes 2∭2No	Specify: Cubar	1	Specify: B1	ack
ğ	e filed within 72 hours after death with the Maryland al Hygiene. I other than "natural", or Items 23a or 28a-f show yent, the Medical Examiner must be notified at	ted	15. Decedent's E (Specify only highest gr	ducation		16a. Deced	dent's Usual Occup	oation during most of work		6b. Kind of Business/	ndustry
215	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. I	DO NOT use retired	d)	ung		
2	lled w Hygier her th	ပ္ပ	17. Father's Name (First, Middle, Las	2			Accountar		e (First, Middle, M	Leather	Company
Maryland	ould be f Mental H a rked ot a rke ev er	o Be	Unknown Edwards						Whitehea		
3	S D E E	Ĕ	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street			City or Town, State, 2	(ip Code)
	and 2 ealth a n 27 is er trai		Robert H. Edwar	ds, Jr. /	Son	1082	l Mapleci			e, Maryland	
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	cerr	netery, crei	sition (Name of matory or other pla	^{ce)} ↓July	Date 26,	20c. Location - City or	
altimore,	trant: If Ite	ı	4 Donation 5 Dother (Special	ify)	Calve		ational Cen				, New York
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Light		M0147	3 Be	thesda-C thesda,	hevy Chas Maryland	e Inc. 20814-35	7557 Wisc 01	neral Home/ onsin Avenue
3			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused y one cause on each lin	the death. ne.	Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	- U.			eumonia				5 Days
	/Medical Examiner		resulting in death)	Due to (or as a						i	3 Months
b	in cons	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated asset of injury	b. Due to (or as a	sphagi a consequer						J Honens
	cuted id ansit	Examiner	triat iriitiateu events	c. Cer	ebrov	ascu1	ar Accid	ent			3 Months
60,	e exe		resulting in death) Last	Due to (or as a	a consequer	nce of):					
6876	eath certificate be executed attending physician and for use as the burial-transit	dical		_ d							
Box 6	certifi nding p	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of del	iverv
<u> </u>	death e atter d for u	iciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	:y		Month	Day Year
P. 0.	at the by the tache	hys	9 Unknown	9□Unknown					T		
ŝ	w requires that the di been signed by the should be detached	by	Part II. Other significant conditions	-		_				acco use contribute to s 2 □ No 3 □ Pr	o the cause of death?
O.C	requi	eted	Congestive Hear				il Fallul				
Records,	has t ge 2 s	Completed	Hypertension, P	ulmonary Fl	LDIOSI	.5			24a. Was ar autops perforn	y prior to death?	topsy findings available completion of cause of
Vita	in: Th		25. Was case referred to medical	1				26. Place of Dea	th (Check only one		2 25 No
<u>-</u>	ysicia is cer direct	o Be	examiner? 1 ☐ Yes 2 2 No	Hospital: 121 Inpatie	ent 2 □ EF	R/Outpatier	nt 3 DOA Oth	nor	,	nce 6 □Other (Spe	cify)
U O	ding Phystcian: The lar n. After this certificate has funeral director, page 2	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day	ıry 2 y Year)	8b. Time o Injury	Wo		28d. Describe ho	w injury occurred	
Sio	Attendii er death. rector: A by the fu	catic	2 Accident investigation 3 Suicide 6 Could not	ho -	At hom	a forma atr]Yes 2 □No	OOF Leasting (Ct	was to and Alicenhau au O	und Davida Alumbar
Division or	or At after d Direc	Certification:	4 ☐ Homicide determined			e, iaiii, sii	reet, factory, office		City or Town	reet and Number or Ri , State)	urar Houte Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			Physician: To the best of aminer: On the basis of							
	the H hin 24 the F mplete	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licens	se number	29	9d. Date signed (Mont	h Day Year)
	To With		29b. Signature and the of certifier		m,1	D	DO	053652	, =	July 15	2007
	INT		30. Name and address of person who	o completed cause of d	lea <u>t</u> h (Item 2	3a) (Type.	Print)			1	,
	10 (1))	140 y	AD ZHIV.	990	1 m	edical	Centert	rive, R.	ockville,	mD20850
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	re	Crarket				th, Day, Year) 1, 2007 1 20850
	Regist	ar	JUL I	2 2041	ELL!	13.					

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Tashema Tamek		7.0	2007 2316
		For State Registrar Certificate of Death Reg. 1. Decedent's Name (First, Middle,Last) 2. Date of Death	No. 3. Time of Death
Physicia Medical Examin	- //	TASHEMA T FITZGERALD Month July 15, 200	ay Year 2025 has
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
		4806 WestLand Blvd. Apt. B	Baltimore County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(I	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		214-11-2393 1□M 2XF 21 Yrs. World Says 10013 WIII JAN, U8	1986 Country MARYLAND
- 4	-	Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b, County	10d. Inside City Limits
ow any		MARVIAIN N/A BALTIMORE CIT	1 X Yes 2 No
rylanc ia-f sh	턍	10e. Street and Number 10f. Zip Code 10g.	Citizen of What Country?
after death with the Maryland all", or items 23a or 28a-f shu ner must be notified at once	Director	1734 N PAUSON STREET 21217	USA
with t	<u>ā</u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
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after all, o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	Specify: BLACK
hours natur Exam	pa	during most of working life. DO NOT use retired)	6b. Kind of Business/Industry
36 in 72 lian " dical	plet	i di	U.S. Security Assoc.
d with	Completed	17. Father's Name (First, Middle, Last) SECURITY 18 Mother's Name (First, Middle, Last)	
21215-0036 uldbe filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	MARK FITZGERALD GLORIA	HENDERSON
	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Number Number of Rural Route Number of Rural Route Number of Rural Rou	er, City or Town, State, Zip Code)
MD d 2 sho Ith and n 27 is		GLORIA HENDERSON AND MARK FITZGERALD 1734 N. PAYSON ST. YBALT	THORE MD. 2/2//
ore, M es 1 and 2 of Health If item 2'		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Carematory or other place) 20b. Place of Disposition (Name of cemetery, Carematory or other place)	
timore, t. Pages 1 a rtment of He rtant: If ite		4 Promation 5 Other Specify: MT. ZION CEMETER 10/-2/-0/1	LANSDOWNE, MD
Baltim Sermit. Pag Department Important:		21. Signature of Funeral, Service Licensee 22. Name and Address of Facility Brown	R. FUNERAL HOME
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespiratory arrespi	shock, or heart Approximate Interval
Physician , /Medical		failure. List only one cause on each line.	Between Onset and Death
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		Sequentially list conditions, b	
	iner	if any, leading to immediate Due to (or as a consequence of):	
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
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68760, certificate be ex nding physician ise as the burial	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
ox 687 eath certific attending p	ciar	22b). Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	I tional bay
s, P.O. Box 68760, irres that the death certificate business that the death certificate business by the attending physic of be detached for use as the bur	Physician/Medic	1 Yes 2 No 9 V Unknown 9 Unknown	
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Division of Vital Records, P.O. Box tall or Attending Physician: The law requires that the death ras fire death. al Director: After this certificate has been signed by the atter led in by the funeral director, page 2 should be detached for u	ed by		2 No 3 Probably 4 Unknown
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Vit	70 5	1 Yes 2 No Indeption 2 ER/Outpatient 3 DOA William 4 Nursing Home 5 R	esidence 6 🗸 Other: Scene
n of 'ding Ph.		(Month, Day,Year)	w injury occurred
ision Attenc rr death rector: by the	Certification	Accident Investigation JULY 13, 2007 FNG 6:33 PM	reet and Number or Rural Route Number, City
Divis	rţį	3 Suicide 6 Could not be or Town, Sta	
<u> </u>		29a. Certifier a Continue Physician To the best of my knowledge, death occurred at the time date and place, and due to the cause	
To the Howithin 24 h	dical	one) 2 • Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date at	nd place, and due to the cause(s)
To wit To COI	Med	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		Terlister O.C.M.E.	July 16, 2007
-		30. Name and address of person who completed cause of death (Item 23a)	
		Zabiullah Ali, M.D. Assistant Madical Examiner 111 Penn Street, Baltimore, MD 21201	
	ate	31. Date filed (Mars), Day, Year) (10) / Registrar's Signature Linear Li	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death) 1. Decedent's Name (First, Middle, Last) Month Day 10.26 AM NNIS 13 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) NIA BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours Min 1**⊠**M 2□F SOUTH Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 □ No MARYLAND Directo 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No ģ BLACK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ZIER ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RONICA FULLARD WAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 □Removal from State ANSDOWNE, MARYLANC 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee samo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): CANCER SOPHAGEAL Sequentially list conditions, if any, cause of the following cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🕱 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

Examiner the death certificate be executed and the burial-tran attending physician use as t ģ detached cate has been signed by the page 2 should be detact ات Vital Records, certificate Physician: funeral director, this ö Hospital or Attending

DENNI

-VLLARD

Division

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Completed by Be Certification: To

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a.	Certifier
	(Check only
	one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number RES-000 29d. Date signed (Month, Day, Year)

JULY 13 2007

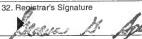
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZUBAIR SHAIKH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239

State Registrar

Medical

31. Date filed (Month, Day, Year)



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

within 24 hours after death To the Funeral Director: completely filled in by the

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar				C	ertificat	e of L	Death			Reg. No.	UU	Ī	201	04
	JV L			ne (First, Middle, L	ast)							2. Date of Do	eath Day	Ye	ar	3. Time of I	
	Physicia /Medic		Richard	Joseph Fo	ehrkolt)						July 1	L7, 20	07		12:0	05A ^M
	Examin		4a. Facility Name (_		mber)				Location of	Death			County of E	Death		
				in Rivers		Apt. I		Colu		T 14 1 1 - 1 - 0	Alles			vard	District	(01-1-	- Firm in
34.	Funeral Director		5. Social Security 217–40–2		Sex 1		vrs. last birthda 64 Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min	8. Date of Bi (Month, D Feb. 1	$\overset{\text{rth}}{2},\overset{\text{Year}}{1}9$	1	Counti	ice (State or Land	Foreign
	pu ,		Usual Residence of	10b. County		100	City, Town or	Location							10	d. Inside City	v Limits
	aryla shov d at	卢														1 🌠 Yes	
	he M 8a-f	ectc	MD	N/A		Ba	altimor		p Code				10a Citiz	en of Wha	t Count	rv?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Nu.	Twin Rive	rs Rd.			2	1044				US.	Α			
	r dea	nue	11. Marital Status		12. Was Dec Armed F	orces?	n U.S. 1	Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Orig ın, Mexican,	jin? (Spe , Puerto F	cify Yes or N Rican, etc.)	0- 1	4. Race - A Black, \			
36	s afte	by Fi		rried 2 Married 4 Divorced	1 MYes If Yes, G Year or D			1 ☐ Yes	2 No	Specify:				Specify:	Whi	te	
ë	hour tural	pe pe	3 LA WILLIAM CONTROL	15. Decedent's		ur	nknown 16a, De	cedent's Us	ial Occup	ation			16b. Kin	d of Busin			
Maryland 21215-0036	in 72	Completed		ecify only highest g	rade completed)		I (G	ive kind of w	ork done o	durina most	of working	ng					
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b	filed I Hyg other	Be C	17. Father's Name	(First, Middle, Las	st)				20110	18. Mother	r's Name	(First, Middl	e, Maiden S	Surname)	TE-	GILY J	all
<u>a</u>	Aenta Aenta rked tlc ev	To E	John H	Foehrkolb						He]	len_I	Fluka					
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Σ	and 2 salth :		Dianna	a Lynn Fo	ehrkolb					River			<u>t. B2</u>	Colu	mbi.	a, MD.	<u>2104</u>
Baltimore,	of He		20a. Method of Di	sposition 2☑Cremation 3	□Removal from	State T	ob. Place of Dis cemetery, of lest Ari	sposition (Na crematory or	other plac	ce)	07	ate		ation - Cit	,	. , -	
<u>Ĕ</u>	Pag ment ant: I			5 Other (Spec		W	est Ar					-18-07	Ode	enton	, M	D	
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			23a. Part1. Enter shock, or he	r the disease, or co eart failure. List on	mplications that ly one cause on	caused the ceach line.	death. Do not	enter the mo	de of dyir	ng, such as	cardiac 6	₹ respiratory	arrest,	,		Interval Bety Onset and D	ween Death
	Physician		Immediate Cause disease or condit	ion	a.	11	leum	me							1	6	
	/Medical Examiner		resulting in death	"	Due to	(or as a cor	nse uer co of):										
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9	bed isit	Examiner	cause. Enter Und Cause (Disease of	derlying or injury	- Cue ic	THE SHEET	ascquence ory									1	
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9	icate be executed physician and s the burial-transit																
68760,	rtificate be executed ing physician and as the burial-transit	Medical			d								17				
Box	0 00		IF FEMALE: 23b. Was decede	ent pregnant	23c. If yes, or								2	3d. Date of	of delive	ry	
m	death cirt	Physician/	in the past 1	12 months?	4□Preg	birth 2 🗆 gnant et time		3 ☐ Ectopic 5 ☐ Other (У				Month	1	Day \	Year
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	requires that the een signed by the	by P	Part II. Other sign	nificant conditions	contributing to	death but no	t resulting in th	e underlying	cause giv	ren in Part I.		23e. Did	d tobacco u			e cause of d	
ğ	equire en sig	ed t										1	Yes 2	No 3	Prob	ably 4 □U	Jnknown
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ita	sician: Th certificate irector, pag	Be C	25. Was case ref	erred to medical						26. Place	of Death	(Check only	1				
r V	ys di S	10		X√No	Hospital: 1] Inpatient	2 ER/Outpa	tient 3□ [4 🗀 Nu	rsing Ho		sidence 6			v)	
0 0			27. Manner of De	eath 5 Pending	28a. Date (Mo	e of Injury onth, Day Ye	ar) 28b. Tim	ry	28c. Inju Wo			28d. Describ	e how injur	y occurred	I		
<u>Si</u>	Attending or death. ector: After by the fune	atic	2 ☐ Accident	turn and the A	ho -			М		Yes 2 🔲			10				.
Division or Vital Records,	ter de lirect	Certification:	3 ☐ Suicide 4 ☐ Homicide	al ada amazina	J ZOU, FIOU	ce of injury - ding, etc. <i>(S</i>	At home, farm pecify)	, street, facto	ory, office			28f. Location City or 7	(Street and Town, State	d Number)	or Hura	ii Houte Nurr	iber,
Ω	urs af		00 0 0 0	17 0	Physician: To the	as best of m	v knowledge e	loath coourre	d at the ti	mo date ar	nd place	and due to th	20 031160(6)	and many	nor se et	tated	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	2 Medical Ex	aminer: On the	basis of exa	mination and/	or investigati	on, in my	opinion, dea	ath occur	red at the tim	ie, date and	l place, an	d due to	the cause(s	s)
	ithin (Mec	29b. Signature a	nd title of certifier	72			2	9c. Licens	se number			29d. Dat	e signed (Month,	Day, Year)	
\	F3F8			MK					D	250	44		7/1	7/0	7		
•	141		30 Name and ac	idress of person wi	no completed ca	use of death	(Item 23a) (Ty	pe, Print)			- /	4	1	/ ()	/		
	At'		m/2	An BN M		717	HAM	HONI	15/	FERI	ey 1	Lef .	BAL	NO	10	212	127
	St	ate	31. Date filed (M	onth, Day, Year)		Registrar's	Signature			17					-		
	Regist			JUL 19	2007	Modern	· B	Coret.	7								

_			1 - For State Registrar	State of Maryla		artment of F rtificate of		F	Reg. No.2007	23165					
	Physic		Decedent's Name (First, Middle, Sharon Anne					2. Date of Dea Month July	L6, 2007 Year	3. Time of Death 4:57p M					
A. A	/Medi Examir		4a. Facility Name (If not institution,	give street and number)		1	r Location of Death		4c. County of Death						
	Funeral		Social Securify Number	morial Hospita	L.L rs. last birthday)	Frede:	If Under 24 Hrs.	8. Date of Birt	rth ay, Year) 9. Birthplace (State or Fore Country)						
	Director		578–56–9067 Usual Residence of Decedent	1□M 2 X F 62	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 30	,1944 Wasi	nington, D.C.					
	Maryland -f show	tor	10a. State 10b. County Maryland Freder:	_	City, Town or Lo					10d. Inside City Limits 1 □Yes 2점No					
	th with the 23a or 28a ist be noti	al Direc	10e. Street and Number 5220 Earles Cour	rt		10f. Zip Code 2170	3		10g. Citizen of What Co United Sta						
9600	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marriet 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ★ O If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 XNo	lispanic Origin? (Sc an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.					
Baltimore, Maryland 21215-0036	d within 72 h giene. r than "natu the Medical	ompletec	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	adent's Usual Occupation e kind of work done during most of work DO NOT use retired) retary		king	Administra	•					
yland ;	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (<i>First, Middle, La</i> Hyman Weinstoc												
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timore	permit. Pages 1 and 2 s Department of Health ar important: If Item 27 is any injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe	□Removal from State Greify)	eoretenass edical	osition (Name of matery or other pla n • Univers Center		20c. Location - City or Washington,	D.C.						
Bal	permit Depar Impor any in		2). Signalure of Funeral Service Li	edn	9	013 Annap	olis Road	d, Lanha	ortuary Ser m, MD 20706	5					
	Dhysisian		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)												
۹	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons	sequence of):	1	- 20								
B	Examiner	ja	Sequentially list conditions,	b. Due to lor as a cons	rationce of:	1 Jai	MAK	-							
	ecuted and transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
68760,	ificate be executed g physician and as the burial-transit	edical Ex		Due to (or as a cons	equence or).				_						
O. Box 6	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time o	etal death 3[⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date of del Month	ivery Day Year					
Δ.	The law requires that the tee has been signed by the bage 2 should be detache	by Ph	Part II. Other significant condition	s contributing to death but not i	resulting in the u	nderlying cause giv	en in Part I.		obacco use contribute to						
Records,	w requires that been signed is should be det	eted						1 🗆 \		robably 4 □Unknown utopsy findings available					
l Rec	The lay	Completed						autop perfo		completion of cause of					
or Vital	Physician: The raths certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Tou	26. Place of Dea	th (Check only o	ne)						
0	g Physer this eral dir	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time o		4 LI Nursing H		lence 6 Other (Spenow injury occurred	cify)					
Division	Attending F r death. ector: After by the funer	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be as Blees of injury. At home form street fortex office.													
Divi	al or Attenos after death	Second Continue Continue													
	To the Hospital within 24 hours a To the Funeral I completely filled														
	To the within To the complete	Me	29b. Signature and title of certifier	* A. 1		29c. Licens			29d. Date signed (Mont						
			30. Name and address of person w	ho completed cause of death (I	tem 23a) (Type,		060417		7.17.0						
			Hemen Sha 31. Date filed (Month, Day, Year)	4,650 Th	omas	Johnso	an Br	Frede	urcic Mt	21702					
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Date filed (Month, Day, Year)

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9 2007

DHMH 17 Rev 1/2001

Registrar

ONES, MO Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 15,16a, b per ab 8869 7-19-0/ vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:05 PM M July 12, 2007 Dorothy L. Hummer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 V F 89 Feb 15, 1918 Maryland 217-07-6789 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifited at 1 ☐ Yes 2√ No MD Harford Bel Air Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA
14. Race - American Indian,
Black, White, etc. 300 Sunflower Drive #362 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: white 9 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 6b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Industrial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sally Olfelia DeVoe John Thomas Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Blades/daughter 208 Krafton Road Bel Air, MD 21014 permit. Pages 1 ar. Department of Heal Important: If item 2 any injury or other? 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Pleasant 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Quasa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) munter pulmoning emblish **Physician** /Medical Due to (or as a consequence of): inkas m **Examiner** vein thanks Sequentially list conditions, if any, is amy to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Exami physician and s the burial-trans Due to (or as a consequence of): 68760, Physician/Medical as 1 attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown O. 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records, DAty Breat carre 1 ☐ Yes R No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? 1□ Yes ∠No 1 ☐ Yes 2 ☐ No this certificate Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ≥ No 2 ER/Outpatient 3 □ DOA မ ō funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Affer 5 Pending **Division** Vithin 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 615 W. MacPhalet Bel Air MD 21314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dubyisky MO PARKICIA 31. Date filed (Month, Day, Year) 32. Mgistrar's Signature State JUL 1 9 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	- Incincin in	Reg. No. 0	7 23168
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Time of Death Year
и	/Media		Louise Heruel	9012	1 20	, , , , , , , , , , , , , , , , , , , ,
	Examir	ier		Location of Deat	_	
_			Genesis Ham, Itom Centur 6040 Harbord Rd Belt. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr	S. 8 Date of Bir	13a/4	
	Funeral Director		239-38-6307 1□ M 2X F 76 Yrs. Months Days Hours Mir	. (Month, Da	l8, 1929	9. Birthplace (State or Foreign Country) Maryland
	/land		10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mar	to	MD Baltimore			1XTYes 2 □ No
	ath with the Marylar 23e or 28e-f show	Director	10e. Street end Number 10f. Zip Code		10g. Citizen of W	hat Country?
	23e	ai	6040 Harford Road 21219		US	SA
	ter dea items inst.m	Funerai	11. Maritel Status unk 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	o- 14. Race Black	- American Indian, , White, etc.
Baltimore, Maryland 21215-0036	0 0 5	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: Year or Dates:		Specify:	white
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardis shock, or heart failure. List only one cause on each line.	ac or respiratory a	rrest,	Approximate interval Between
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ă	or effe	Certification:	4 ☐ Homicide building, etc. (Specify)	City or To	wn, State)	
	To the Hospital or Attending Physician: The lew within 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edlcai	29a. Certifier (Check only one) 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place (Check only one) 29a. Certifier (Check only one) 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place (Check only one) 29a. Certifier (Check only one)			
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			Registrar 1. Decedent's Name (First, Middle,	Last)			illical	COL	Jean		Re 2. Date of Death	g. No.	UUI	3. Time of	Death
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Mai d2 st th and 7 te n traun			19a. Informant's Name/Relationship		C	327		_			Route Number,				
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 221 is marked other than "natural; or items 23a or 28a-1 ehow only lojury or other traumelic event, Ite Madical Examiner may be notified as		- 0	Mr. Richard J. H	onnas /	Son	27 Y	ew Ro		Balt	imore Da	e Mary]		21221 on - City or T		
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VISION Of Vital Attending Physician: or deeth. ector: After this certifice by the funeral director, p	P		1 Tes 2 No			☐ ER/Outpatier			4 CINUIS		e 5□Resider			fy)	
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Division of Vital Records, to attending Physician: The law requires to plete deeth. Director: After this certificate has been signed in by the funeral director, page 2 should be to	Certification:		4 Homicide determine	build build	ting, etc. (Spe	cify)	eet, lactor	y, once		20	City or Town,		IIIDer Or Aur	ar noble Null	Der,
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I 4 II 0	edicai		(Check only 2 ☐ Medical Ex	aminer: On the l	pasis of exami nner stated.	ination and/or in	vestigation	, in my op	oinion, death	occurred	d at the time, dat	te and plac	ce, and due	to the cause(s)
To the within 2 To the complet	ž	•	29b. Signature and title of certifier	- 9				c. License				d. Date sig	ned (Month,	-	
			· Unuk	SU	2 ,	MD		DO	0610	107		-	7/1-	1107	
6		;	30. Name and address of person wi	T \	se of death (it		Print)		Bull			M 75			
			On WK W Um (112L Registrar's Sig	+ Mac	KV	٤,	17111	1m	ore, '	M 17	212	21	
	State istrar	ľ	31. Date filed (Month, Day, Year)	007	Separat of Signature	J. Santa									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 1 13:43 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A SALTIMORE CIT.
If Under 1 Year | If Under 24 Hrs. HOPKINS JOHNS HOSPITAL 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F 216 36 1338 73 Director OCT.18,1933 CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Tyes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1618 E. CHASE STREET 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: BLACK 3 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11THHOUSEWIFE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIE FOSTER LILLIE MAE JONES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARY HOSLEY GRIFFIN (daughter) 1618 E. CHASE ST. BALTO, MD. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Onation 5 Other (Specify) OAKLAWN CEMETERY JULY 24,2007 BALTIMORE, MD. 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME nature of Funeral Service Licensee 1412 E PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONIA disease or condition resulting in death) DAYS Due to (or as a consequence of): ENCEPHALOPATHY INFECTIONS 2 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner KLEBSIELLA PNEUMONIA WEEKS Due to (or as a consequence of): Physician/Medical OBSTRUCTIVE PHLINONARY YEARS IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JULY, 16, 2007 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND, 21287 HARLES HAINES THE JOHNS HOPKINS HOSFITAL, 600 NORTH WOLFE STREET, BALTIMORE 3. Registrar's Signature

Registrar

31. Date filed (Month, Day,

Year)

filled in by the funeral

completely

noch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . 2007 DEMETRA JAASUND July 15, 12:20P ^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 23, 9. Birthplace (State or Foreign Country) New York 6. Sex 7. Age (In vrs. last birthday) Year) Days 1 M 2 XX 88 053-14-6515 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **XX** No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 💥 No Specify: White Specify: 3**X**Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Gianakouros Kleoniki Rosaki 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lisa M Close DTR 4205 Delight Court Hampstead Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 🖟 Burial 2XXCremation 3 □ Removal from State Green Mount Crematory: 7/17/07 Baltimore, Maryland □Donation 5 □ Other (Specify) 21 Sgnature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Immediate Cause (Final disease or condition resulting in death) ence Acute Due to (or as a consequence of Spornton Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Chronie

Examiner Records, P.O. Box 68760 the Hospital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f shov sdical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Directo

by Funeral

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resulting in death) Last	Due to (or as a consequence of):		1 1		U
	d traumatic rib	Fractures w	Th hemot	horay	weeks
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	ic pregnancy r (specify)		23d. Date of del Month	livery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobacco u 1 ☑ Yes 2		o the cause of death? robably 4 □Unknown
			24a. Was an autopsy performed? 1☐ Yes 2 ☑ No	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?			nth (Check only one)		
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27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury 1997	28c. Injury at Work?	28d. Describe how injur	y occurred	sell getting a
2 MAccident investigation		1 ☐ Yes 2 ☑ No	of the shou		hing for horus
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, fact building, etc. (Specify)	ctory, office	28f. Location (Street ar	nd Number or Ru	ural Route Number, 70
29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowledge, death occur inner: On the basis of examination and/or investigation and manner stated.	rred at the time, date and place	and due to the cause(s	and manner as	s stated. e to the cause(s)
29b. Signature and title of certifier	ing Llynn	29c. License number $D25205$		te signed (Mont	
30. Name and address of person who	completed cause of death-(tem 23a) (Type, Print)	Charles St.	Balto. M.	d 212	of
31. Date filed (Month, Day, Year) JUL 1 9	2007 Klow & Span	le			
	ODICINI	1 /			

Stat Registra 07-05181 Cassandra James Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

sandra Jame			e of Maryland / Depar	tment of ificate of	Health a Death	nd Mer	ntal Hyg	jiene Reg.	200	17 23171
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Funeral		Social Security Number 6.	Sex 7. Age (In yrs. las	st birthday)	If Under 1 Y	ear If Und			Fore	ign .
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36 in 72 han "	bet	Elementary/Secondary (0-12)	0	nor	ne.			In No.	none	٤
5-0036 shed within 7 Hygiene. I other than	Completed	12 17. Father's Name (First, Middle, L				18.Moth	ner's Name	(First, Middle, Ma	aiden Surname)	unk
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D 21215-003 should be filed within and Mental Hygiene. 7 is marked other thematic event, the Med	10 B	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailin	g Address (S	treet and N	lumber or R	tural Route Numb	er, City or Town, Sta	ote, Zip Code) .0735
MD and 2 short alth and m 27 is aumatic	-	Brenda Myles/a	dopted mother					5 Clint	20c. Location - City	
	ļ	20a. Method of Disposition 1 Burial 2 Cremation		Place of Dispos crematory or ot	sition (Name o her place)	t cemetery,		Date	200. 2000.011 0.19	
DOF ages art of othe		1 Bunal 2 Cremation 4 Donation 5 X Other Spe								
Baltimore, permit. Pages 1 at Department of Her Important: If ite		21 Signature of Funeral Service L Anthony	icensee Pleagant	22.	Name and Add	ress of Fac	ility 7 Boar	d 655 W	. Baltimo	re Street
iii ii Pe B	1	Chilhony !	Diesan	/ I R	altimon	MT م	1 212	2O L		Approximate Interval
Physician		23a. Part I. Enter the disease, or c failure. List only one cause of	complications that caused the death on each line.	. Do not enter	(ile illoue of d	ying, such c	20 001 0100			Between Onset and Death
/Medica Examine		Immediate Cause (Final disease	a. Chronic pancreatitis Due to (or as a consequence of	v ().						
_/	ļ	or condition resulting in death)	b	,,,.						
	je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a consequence of	of):						
cuted	Ľ,	events resulting in death) Last	d							
exe an a	dical	UNPENDED	AMENDED							
60, ate be			23c. If yes, outcome of pres			3 Fc	topic pregna	ancv	23d. Date of deli Month	Day Year
cath certificate be attending physical	Dhyeirian/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of d		etal death Other (Specify		topio prog			
Box e death c the atten	10	1 Yes 2 No 9 🗸 Unk	7	0(J(116) (0,000.)	,				
~ ± ≥ ≥			ons contributing to death but not	resulting in the	underlying ca	suse given i	in Part I.		bbacco use contribut	e to the cause of death? Probably 4 Unknown
P.O.										e autopsy findings available
rds, requir	Should							24a. Was autop	osy prio	r to completion of cause of
COT law e has	15 7 at							1 ✓ Yes	THE STATE OF THE S	Yes 2 No
Re iffcat					26		eath (Check	only one)		
'ital sician is cer	5 D	examiner?	Hospital: 1 Inpatient 2	✓ ER/Outpatie	nt 3 DO	A Othe	4 Nurs	ing Home 5	TROOLEGE TO THE TENT	Other:
Division of Vital Records, rate or Attending Physician: The taw requir rs after death.	ᇛ 1	27 Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o		c. Injury at		28d. Describe	how injury occurred	
Sinding	he fur	1 Natural 5 Pend	ding			1 Yes				DI Davida Number City
r Atte	filled in by the		28e. Place of Injury - At	home, farm, st	reet, factory, o	office buildir	ng, etc.	28f. Location (or Town,	Street and Number (State)	or Rural Route Number, City
Div ital o	lled i	Homicide dete	rmined (Specify)							
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director:			hysician: To the best of my knowle aminer:On the basis of examination	edge, death oc	curred at the t	ime, date ar oninion, dea	nd place, ar ath occurred	nd due to the cau I at the time, date	se(s) and manner as and place, and due	to the cause(s)
o the	completely	0	and manner stated.	l alid/or ilivest		License nu			29d. Date signed	(Month, Day, Year)
FSF	°	29b. Signature and title of certific	ar ()			O.C.M.E			July 7, 2007	
		Milyone	megnell							
_			n who completed cause of death (Ite Assistant Medical Exam	_{em 23a)} i ner 111	Penn Stre	et, Baltir	more, MD	21201		
		Margarita Korell MD.		aturo -	62					
	Sta	12 31. Date filed (Month, Day, Year)	52. Iteristial 3 Sign	L.	1 1					

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attending physician and for use as the burial-trar signed by the a

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after Funeral Direct 24 within 24

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 04 **Physician** 9:3-AM JULY JUNES 200 WALLACE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Bon Secours Hospital If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea May 1, 19 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F 73 North Carolina 241-50-5554 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show my no other than "natural", or items 12 is marked other than "natural", or items 12 is marked other than "natural", or or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at ty∑Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2303 W. Lexington Street 21223 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Baltimore, Maryland 21215-0036 Specify. Specify: black 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gurtha Harris Wramil Jones ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2303 W. Lexington Street Baltimore, MD Josephine Jones/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 N Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Ant hony D 22. Name and Address of Facility
State Anatomy Board 655 w. Baltimore Street Pleasant Baltimore, MĎ Teasan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEFEBRO-VASCULAR ACCIDENT 8 DAYS **Physician** ACUTE /Medical Due to (or as a consequence of) **Examiner** 11 CONGESTIVE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine UNILNEWA ARTERIOSCLEROTIC Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ ME 211 1 Yes 2 No 3 Probably 4 PUnknown DIA BETES Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b autopsy performed: LURE 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Prinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and due to th 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 23300 MA JULY BON SECONIRS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21223. 13A-2TO MD. 2000 W, BALTO ST. PATE2 SUDHIR D Registrar's Signature 31. Date filed (Monta State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #23e, perME, g870, 8/2/2007 TCertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 10065 Physician 200 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospi tal Baltmork Hookins Sohns If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **X** M 2 □ F Social Security Number Days **Funeral** Hours Months New York May 19, 1960 47 132-56-5860 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or Items 23a or 28a-f show 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director Randallstown MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21133 3701 Vega Rd. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical College (1-4or 5+) Elementary/Secondary (0-12) **TRS** Revenue Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental n and Mental Jacqueline Blaut Arnold Jacobs 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3701 Vega Rd., Randallstown, MD 21133 f Health item 27 i Maryanne Jacobs- wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 7/19/2007 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Qther (Specify) 22 Name and Address of Facility Loring Byers Funeral Directors, INC 21. Signature of Funeral Service Licensee 8728 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WILLE Failur **Physician** Henr Due to (or as a consequence of): /Medical weeks Examiner oin-dial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of): Examiner that the death certificate be executed provary physician and is the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No. 24a. Was an autopsy performed? 2 2 1☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 2[**X**No 3□ DOA 1 ☐ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No ispital or Attendlinours after death.

neral Director: A
y filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death account of the cause(s) and manner as stated. To the Hospital within 24 hours a To the Funeral L 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17,2007 RES-000

State

North Wolfe Street Baltimole, Maryland

DO

32. Registrar's Signature

Alexander

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ehrer

31. Date filed (Month, Day, Year)

Timothy Johnson	State of Maryland / Department of Health and Mental Hyon Certificate of Death State of Maryland / Department of Health and Mental Hyon Certificate of Death	glene Reg. No. 2007 23175
Physician/	1. Decedent's Name (First, Middle,Last)	Date of Death Month Day Year 0406 hrs
N A Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	July 12, 2007 0406 nrs 4c. County of Death
	Johns Hopkins Hopital Baltimore	NA
Funeral Director	213-96-7260 12M 2 F 37 Yrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) M.P.
nu v	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
show ind	MD NIA Baltimere	1 Yes 2 No
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If iten 27 is marked other than "natural", or itens 23a or 28a-f show any or other traumatic event, the Medical Examiner mast be notified at ouce. To Be Completed by Funeral Director	10e. Street and Number 400 South Bond Street 21231	10g, Citizen of What Country? (1) Hed States
er death with , or items 23 : must be no Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spering Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 14. Was Decedent of Hispanic Origin? (Spering Never Married 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto R	
ter dea	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify:	Specify: Black
ours af atural xamin	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire	rk done 16b. Kind of Business/Industry
5-0036 ed within 72 hours aft fygiene. other than "natural" the Medical Examina Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	Construction
d withing ygiene ygiene ther the Med	17. Father's Name (First, Middle, Last) 18.Mother's Name (I	First Middle, Maiden Surname)
21215-0036 und be filed within 7 Mental Hygiene. marked other than e event, the Medica for Beauty, the Medica for Be Comple	O'Neil Johnson Lula	Juanta Smoth
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other ti injury or other traumatic event, the Med	Lula Smith - Mother 2202 Cellow Ave.	ral Route Number, City or Town, State, Zip Code) Apt: 2 B. Ho: MA 212 17 Date 120c. Location - City or Town, State
Ore, ges lar of Hez If ite	1 Burial 2 7 Cremation 3 Removal from State crematory or other place)	Date 20c. Location - City or Town, State Ba Humine, Mary land
ltim it. Pag urtment ortant:		
Balt permit. Departu Import injury	Calvind. he there of 10 130 to 1/65	1 Ayus Lawred Service, P.A.
ysician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	Between Onset and
Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Stab Wounds of Chest Due to (or as a consequence of):	Death
-a	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
red nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	
nuted ransit	events resulting in death) Last Due to (or as a consequence of): d.	
50, te be executed sysician and burial - transit	UNPENDED AMENDED	
Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be rafter death. The law for the rest of the	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan	23d. Date of delivery Cy Month Day Year
Box 6876 he death certificate the attending phy her for use as the li hysician/M	past 12 months? 4 Pregnant at time of 5 Other (Specify)	
). Box 6876 the death certificat oby the attending ph ched for use as the Physician/IM	1 Tes 2 No 9 Unknown	23e. Did tobacco use contribute to the cause of death?
P.O. s that the general by e detace	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 _ Yes 2 ✔ No 3 _ Probably 4 _ Unknown
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ecol ne law te has ge 2 sh		autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rection: The certifical rector, page Co.	25. Was case referred to medical 26.Place of Death (Check or	
FVICT Physici arthis c	Tes 2 No	Home 5 Residence 6 Other:
nding I th.: Afte e funer		28d. Describe how injury occurred subject stabbed
risio r Atter er deal irector n by th	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2	28f. Location (Street and Number or Rural Route Number, City
Division o spital or Attending tours after death, neral Director: Aft filled in by the fune Certification:	4 ✓ Homicide determined (Specify) Alley	or Town, State) 29 Herring Court, Baltimore, MD
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and cone) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	
io the Ho within 24 To the Fu completely	and manner stated. 29b. Signeture and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	July 12, 2007
à l	30. Name and address of person who completed cause of death (Item 23a)	
7	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1
State Registrar	31. Date filed (Month, Day, Year) 32. Restrar's Signature	
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eslie Leonard K	1	- For State	State	ot iviaryian		rtment of tificate of			Menta	ıı myç		eg. No.	200		23176
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ledical Examir			Gordon Ke								July 17, 2		unty of Deat		1113
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Funeral		5. Social Security N	tumber 6. Se	x 7.	Age (In yrs. la	ast birthday)	If Under		If Under	24Hrs. Min.	8. Date of Bi	th (MM/DD/	YYYY) g. B Fore	irthplace (St ign	ate or
Director		215-30-3	3519 ₁ X	M 2 F	73	Yrs.	Months	Days	Hours	IVIII.	Feb.	8, 19.	34 c	ountry) M	D
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215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be natified at once									Evely	n H	ornung				
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MD d 2 sho lith and n 27 is aumati		Sherry_	A. Kemper	/Wife_	Took	1239 Place of Dispos	Stev	ens	Avenu	ie A	<u>rbutus</u> _{Date}	Md 2	1227	or Town, Sta	ate
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٩ -	Examiner	(Disease or injury events resulting in		Due to (or as a	consequence	of):									
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Sox 6876(death certificate e attending phy. I for use as the b		IF FEMALE: 23b. Was deceden		23c. If yes, o	utcome of pre rth		etal death	3	Ectopic	pregna	ncy		lonth	Day	Year
Box 6876 e death certificate the attending phy ed for use as the	Physician/M	past 12 month		4 Pregna	ant at time of d		ther (Spe	cify)							
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Rec The la icate h	ह										1 Yes	2 No	1 🗸	Yes	2 No
Division of Vital Records, tal or Attending Physician: The law require is after death. Director: After this certificate has been siled in by the funeral director, page 2 should b	Be	25. Was case refe examiner?		Hospital:		ER/Outpatien		26.Place DOA	of Death Other		only one) ng Home 5	Resident	ce 6 🗸 O	ther: Scene	
of Vi ing Physi After this uneral dir	₽	1 ✓ Yes 27. Manner of De	2 No	28a. Date	npatient 2	28b. Time of			ry at Work		28d. Describ				
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ISIO Atter or deat rector by th	icat	2 Accident	Investiga	Jul 17, 2	007 e of Injury - At	0530 hrs home, farm, stre	et, factory	, office b	ouilding, et	C.	28f. Location	(Street an	d Number or	r Rural Route	e Number, City
Div tal or tal or al Dir	Certification:	3 Suicide 4 Homicide	6 Could no determin	ot be	Single Fa						or Town 1239 Steve	, State) ns Avenue	e, Halethor	pe, MD	
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the L		29a. Certifier (Check only	Certifying Phys	cian: To the bes	t of my knowle	edge, death occu	irred at the	e time, d	ate and pla	ace, and	due to the ca	use(s) and	manner as	stated.	(-)
o the ithin 2 o the o the mplet	Medical	one) 2		er:On the basis of and manner st	of examination	and/or investiga	ation, in m	y opinior	n, death oc	curred a	at the time, da	te and plac	e, and due t	the cause	
ESES	¥	29b. Signature ar	nd title of certifier	. 1			29		se number			- 1		(Month, Day	, year)
			2008 h	Je 9	7/	(1)		O.C.	M.E.			July	17, 2007 ———		
441			dress of person wh				Donn (Stroot	Raltima	re Mi	D 21201				
		C 101	eenberg MD.	Assistant M	edical Exa		renn	sueet,	Daluilli	n €, IVII	1201				
	State	31. Date filed (Mo		2007	yısırar s sıyıla	To An	BALL D								

amend 29a per IVR 12/19/07 KHH lease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10 19869 7-19-07 vt. State of Maryland 7 Department of Health and Mental Hygiene - State
Registrar amend 1 per Dr. g871 9/28/07 ificate of Death

1. Decedent's Name (First, Middle, Last)

Kpan

Baby Boy Lapn Twin B 2. Date of Death 3. Time of Death Day Month Year **Physician** 1925 PM Jali 2001 /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Johns Horkins Haspital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 2007 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumattc event, the Medical Examiner must be notified at Montgomery Silver Spring 1 ☐ Yes 2 ☐ No MD Director Wicomico Salisbur 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3052 Bel Pre Road 20906 USA Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No black. Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Kimberly Kpan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) the Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 21. Signature of Funeral Service Licensee Antichony D Rleasant 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Casani Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) extreme trematurit **Physician** Minute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in reduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physiclan; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1∐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Xes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 2007 so de 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 600 N. Groduich Wolfe St.

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Baby Boy Kpan Twin A 2007 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore HOPKINS Hospital Theelohn Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Min. Days Hours 1 X M 2 □ F Maryland Director 1 30 July 7, 2007 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits show 10a State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2√ No MD Montgomery Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 3052 Bel Pre Road 20906 Funeral USA 14. Race - American Indian, Department of Health and Mental Hygiens after Usa Important: If Item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by 3 Widowed 4 Divorced black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Kimberly Kpan ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Anthony D. Pleasant -Baltimore, MĎ 21201 esan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) xtrem 9 Minuk **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any learning to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe /es 2 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

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6 ₩ W.

32 Registrar's Signature

Wolfe St. Bultimere,

			For State of Maryland / Departm 1- Registrar Certific	cate of Death		.No. 2007 22179					
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death					
	/Medic	al	HELEN LOUISE KEIL	City, Town, or Location of Death	JULY	7, 2007 5:45 P ^M 4c. County of Death					
	Examin	er									
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	FREDERICK Under 1 Year If Under 24 Hrs. Inthis Days Hours Min.	8. Date of Birth (Month, Day, Youly 31,	FREDERICK 9. Birthplace (State or Foreign Country) 1912 Missouri					
ī	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n		10d. Inside City Limits					
	Marylan -f show fied at	tor	MD Frederick Frederick	k		1 □Yes 2√√ No					
	th the)irec	10e. Street and Number	of, Zip Code	10g	. Citizen of What Country?					
	ath wi	rai	7407 Willow Road	21702	- it. V N-	USA 14. Race · American Indian,					
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mertal Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show if them 27 is marked other than "natural", or items 21a be notified at or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No	Decedent of Hispanic Origin? (Sp. s, specify Cuban, Mexican, Puerto res 2X No Specify:	Rican, etc.)	Black, White, etc. Specify: white					
5	72 ho natur dical E	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind of Give kind of Gi	s Usual Occupation of work done during most of work IOT use retired)	ing 16	Sb. Kind of Business/Industry					
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<u> </u>	shouid be nd Mental marked c	To B	William Earl Wilson	Selma N	ickolina	Sodergrin					
Id	2 sho n and is ma rauma			Idress (Street and Number or Run							
ב ט	1 and 3 Health lem 27		20a Method of Disposition 20b. Place of Disposition	7th Street Fred		21701 Dc. Location - City or Town, State					
Dallillion	Parit:		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 22 Nac								
ם ח	permit. Departi importa any Inj		Putting Leasan Balt	<u>imore, MD 2120</u>	1	Baltimore Street					
	Physician /Medical Examiner	e.	Ede F (o sa d astrançación o sa).	cardial or carried or		Oneet and Death					
Ď,	ificate be executed g physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):								
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O. BOX	sician: The law requires that the death certif certificate has been signed by the attending rector, page 2 should be detached for use a	Physician/M		opic pregnancy ner (specify)		23d. Date of delivery Month Day Year					
λ, Γ	s that ined by e deta	by Ph	Part II. Other significant conditions contributing to death, but not resulting in the underly	ying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?					
cord	requires een sign	ted t	Sever dorte Stenosis, OS	esporasis	1 □ Yes	No 3 Probably 4 Unknown					
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VItal	Physician; this certific ral director,	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Inputient 2 ER/Outpatient 3	Othor	h (Check only one)	ce 6 Other (Specify)					
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	al or Att saler de al Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, f building, etc. (Specify)	factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)					
	To the Hospital or Attending Physician: within 24 hours a ler death. To the Funeral Director: After this certific completely filled in by the funeral director.	ledical (29a. Certifier (Check only one) 1/2 Certifying Physician: To the best of my knowledge, death occ and manner stated. 1/2 Certifying Physician: To the best of my knowledge, death occ and manner stated.								
	To th withir To th comp	Me	29b. Signature and bite of certifier	29c. License number	294	Date signed (Month, Day, Year)					
)		1	30. Name an 3 dress of per n n to complete cause of death (Item 23a) (Type, Print)	123/83		Uly 4, 2007					
			Ali'S Areales 300 Wes	of gth St	Taleric	A, MD.					
	g Sta Registi		31. Date filed (Month, Day, Year) JUL 1 9 2007 32. Begistrar's Signature	W							

			1 - For State Registrar	State of Ma		partment of ertificate of			giene Reg. No. 2 0 0	7 23180
			Decedent's Name (First, Middle, Last)				· · · · · · · · · · · · · · · · · · ·	2. Date of Dea	ith	3. Time of Death
м	Physici /Medi		William			Kaine		Month	Day Yea	. 06:4/ 14
j.	Examir		4a. Fecility Name (If not institution, give	street and number)			or Location of Death	1	4c. County of De	
			The Johns Hopkins	Bayview H	ledical Cente	Y BALT	MORE		N	/A
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthda			8. Date of Birth (Month, Day Sept 16	9. E	Birthplace (State or Foreign Country)
ш	Director		227 31 7030	1W 2UF	68 Yrs.	Morning Bays	TIOUTS WILL	Sept 16	5, 1938 M	aryland
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Aaryli r •ho	ō	Maryland Baltimor			ingham				1 ☐ Yes 2 No
	28a-	ect	10e. Street and Number	e	NOLL	10f. Zio Code			10g. Citizen of What	
	with a or	ā	21 Burnsway Court			212	36		USA	Country:
	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow the Madical Exeminer must be notified at	Funeral Director	· · · · · · · · · · · · · · · · · · ·	12. Was Decedent Ev	ver in U.S. 1		Hispanic Origin? (S	pecify Yes or No-		merican Indian,
(0	r her	Fun	1 Never Married 2 Married	Armed Forces? 1 □XYes 2 □ No	1001	If Yes, specify Cul	oan, Mexican, Puert	o Rican, etc.)	Black, W	hite, etc.
ဗ္ဗ	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1963	1 ☐ Yes 2, ♠ No	Specify:		Specify:	White
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation		cedent's Usual Occu	pation during most of work	kina	16b. Kind of Busines	ss/Industry
2	ithin a	nple	Elementary/Secondary (0-12)	College (1-4or 5+	life	. DO NOT use retire	ed)	All 19	.	
N	filed w Hygier Sther th	Cor	12		Secu	rity Offi				ecurity Firm
밀	ital H d ott	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
3	Mer Merke	ပို	Wilbur Kaine				1	Woods		
Maryland	h and 7 Is n	1	19a. Informant's Name/Relationship (Ty	· ·					r, City or Town, State	
	1 and Healt em 2: ther		Janice E. Kaine,	wire		position (Name of	Court Not	LINGHAIII,	Maryland 20c. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Medial Hygiene. Important: If Item 27 is marked other than "naturel; or Iteme 23s or 28s-f show enty injury or other traumatic event, the Medical Extendition and be notified at another.		1 ☐ Burial 2 ☐ Cremation 3 ☐ P	emoval from State	cemetery, c	rematory or other pla				, Maryland
틀	rtant njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service (Conse			ematory I	1			, ,
Ba	Depermine Deperm	ļļ	I Momas Dr	-		Cremation	Society	Of Maryl	land, Inc. ore, Maryl	1 01000
	_		23a. Part 1. Enter the disease, or compli	cations that caused the	ne death. Do not e	299 Frede	ing such as cardiac	or resouratory arr	ore, maryi	Approximate
			shock, or heart failure. List only or fmmediate Cause (Final	e cause on each line	•		3,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		LENSIO	2				24 Hours
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/	uted d ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	NEURO	GENIC	BLAN.	DER			5 YEARS
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Division of Vital Records, P.O. Box	The law requires that the death certifica te has been signed by the ettending pl sage 2 should be detached for use as t	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2		Ectopic pregnanc	ev .		23d. Date of c	
	e des	Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tii 9☐ Unknown	me of death	Other (specify)			Month	Day Year
<u>~</u>	hat th d by detacl	F.	Part ff. Other significant conditions con	tributing to death but	nat requiling in the		in Don't	22a Didas	h	A. M
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<u>a</u>	ician: Th certificate rector, pag		_					1 Yes	med? death 2□No 1□Yo	
⋚	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:		_ Ot	har	th Check only on	75	
ō	Phys r this ral di	H 1	1 Yes 2 100	28a. Date of Injury	2 ER/Outpati	ent 30 box	4 Linuising H		ence 6 Other (Spow injury occurred	pecify)
0	ding th.	ţį	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)	rear) Injury	Wo	ork?]Yes 2 □No	200. 2000120 110	on injury occurred	
/ISI	Attending in death.	fica	3 Suicide 6 Could not be	28e. Place of Injury	/ - At home, farm,	street, factory, office		28f. Location (Si	treet and Number or	Rural Route Number,
á	al or s afte	Certification:	4 Homicide determined	building, etc.	(Specify)	•		City or Towi	n, State)	
	ospit hour uners ly fille		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, de	ath occurred at the t	ime, date and place,	and due to the c	ause(s) and manner	as stated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	Medical	one,	ier. On the basis of e and manner state	d.					
	To	Σ	29b. Signature and title of certifier				se number	1	9d. Date signed (Mo	
•	141			tions, 1			000-2		July 16	,2007
	17		30. Name and address of person who co			•				
	Sta		PRISCILLA BRASTIAN 31. Date filed (Month, Day, Year)	32. Registrar	s Signature	CASTER	AVENU	E BALT	IMORE, M	10 TISSA

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 7 per fb 9869 7-19-07 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 200 /Medical acility Name (If not institution, give street and number Examiner MUSONIC 6. Sex Age 94 **Funeral 1**□M 2 Director MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 300 International Circle 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify ρ Specify: white 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Artist Art 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard McKindless Marguerite Derlin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2316 Monkton Rd., Monkton, MD 21111 Norman Kayler/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Greenmount Cemetery 17/21/07 Baltimore, MD 21. Signatur f Funeral Service Lib ns 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications 1 at ca sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death Dan Scheeter Immediate Cause Final disease or control on resulting in death) **Physician** Vasculen yeeus /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immuce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner and burial-trar Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 Probably 4 Xunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ms 30. Name and address of p son who completed cause of death (Item 23a) (Type, Print) Internation Circle Cart 300 Day, Year) UL 1 32. Pogistrar's Signature 31. Date filed (Month)

Registrar DHMH 17 Rev 1/2001

State

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Please Type or Print in Black Indelible Ink Figure All Copies Are Legible.

AMEND AMEND PETH, G869, 7/19/07, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** DOROTHY D KOHANSKI 3:20 A M JULY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner **VANTAGE HOUSE** HOWARD COLUMBIA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 1 M 2 7 F Months Days Hours Min. 533-16-4809 86 WASHINGTON, DC 05/15/1921 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 VANTAGE POINT ROAD APT #908 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No WW II Year or Dates: 14 Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No à Specify WHITE Specify 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER/ADMINISTRATOR EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MOSES DELLAR ADELE GREENWALD 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD KOHANSKI / SON 6085 COVINGTON ROAD - COLUMBIA, MS 21044 20a. Method of Disposition 20c. Location - City or Town, State HEBREW YOUNG MEN Place) 1 Burial 2 □ Cremation 3 □ Removal from State 07/18/2007 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) as a consequence of) Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Sleedi-IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1⊟ Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 TYes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, signed by the a ate has page 2 s certificate To the Hospital or Attending Physician: director, this funeral After s after death.

I Director: / within 24 hours are Lothe Funeral Direct

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be marriand once.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

State Registrar (Check only

29b. Signature and title of certifier

29c. License number

(le 23a) (Type, Print)

31. Date filed (Month, Day, Year)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TOR 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner BALTIHORE RIVE GOOD SPRI NG 9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day) **Funeral** Months 1□M 2XF 062-30-7442 TUNE Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Completed by Funeral Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 3 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LAUNDRY MANAGER MEDICAL (MASTERS) 18. Mether's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AVID KSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 GOOD SPRING DR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 ☐Removal from State WOODLAWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee JR, FUNERAL HOME BALTO, MD 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BONE MARROW **Physician** /Medical Due to (or as a consequence of): Due to (or as a conse) nce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Certification: To Be Completed by 2XNo 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours at To the Funeral D filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the I 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CN @ Johns Hopkins Sidney 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

ORIGINAL

132AF

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) JUL 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD



ORIGINAL

D0058 580

29d. Date signed (Month, Day, Year)

07/17/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yea SOPHIA 6:29 PM MILLER 200 MILL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** of Mary land Medical Center BALTIMORE University If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, You Dec. 20, 9. Birthplace (State or Foreign **Funeral** 1929 Days 1 ☐ M 2 💢 F Director Maryland 217-26-3664 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov r than "natural", or Items 23a or 28a-f show MD N/A 1 XYes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 may lolury or other traumatic event, the Medical Examiner must be none. 2407 Herkimer Street 21230 U.S.A by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Charity 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Sienkiewicz Apolinia Romaniski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Haspert/Daughter 5516 Dolores Avenue Arbutus MD 21227 20b. Place of Disposition (Name of cometery, crematory of other place)
Meadowridge Memorial
Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-18-2007 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S to ice License Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial intarction **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it are leading to in a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 212 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Other: 4 Nursing Home 5 Residence 211 No Certification: To 6 ☐Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: A 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral [1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Cecily md agraous MD 1265634166 13 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGCAOILI, 22 S. GREENE ST., BALTIMORE MD 21201 CECILY MARIE L 31. Date filed (Month, Day, Year) 32/Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		State of Ma	liylallu	-	tificate of	Death		Reg. No.		0000
apri,	Physicia		1. Decedent's Name (F	First, Middle, Last) J. MAS(~ A D T					2. Date of Dea	ath Day	15. YEV	3 Time of Death U
}	/Medic Examin	al	4a Facility Name (If no		reet and number)	l Car	ton	4b. City, Town,	or Location of Death			County of Dea	
	Funeral Director		5. Social Security Number 217-38-9	ber 6. Sex	7. Age	e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt (Month, Da 5/23/	h Y, Year) 194	9. Bir	thplace (State or Foreign ountry) RYLAND
	D		Usual Residence of De 10a. State 10	ecedent 0b. County		10c. City, 1	Fown or Loc	ation					10d. Inside City Limits
	Maryla -f sho fied at	tor		BALTIMO	RE	I	UTHE	RVILLE					1 □Yes 2 No
	with the a or 28a be noti	Director	10e. Street and Number		RD			10f. Zip Code 210	93		-	en of What Co	ountry?
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married	1	2. Was Decedent I Armed Forces?		13. V		Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whi	
036	ours aft ral', or Exami	by	3 ☐ Widowed 4 ☐	,	1 XYes 2 ☐ N If Yes, Give Year or Dates:	MIL. GA	urgo 1	☐ Yes 2 128, No	Specify:			21 50 1	HITE
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212	ed within 'giene. er than " the Mec	S mo	Elementary/Seconda		College (1-4or 5	i+)	MORT	GAGE B				ANKING	3
and	I be filed ntal Hygi ed other event, t	Be	17. Father's Name (Fir NICHOLAS		CART				JOSEPH	e (First, Middle, HINE RE		Surname)	
Maryland 21215-0036	2 should b and Ment is marked raumatic e	2	19a. Informant's Name JUSTIN MA	e/Relationship (Typ	e. Print)				t and Number or Ru	ral Route Numb	er, City or		Zip Code) MD • 21093 •
	es 1 and of Health f item 27 r other t		20a. Method of Dispos	sition		20b. Plac	ce of Dispos	sition (Name of natory or other pla	ace)	Date	20c. Loc	cation - City or	Town, State
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Bal	permit. Pag Department Important: I any Injury o		21. Signature of Fune	Clave	1				. JENKIN ORK RD.			CO. D. 21	111.
			23a. Part1. Enter the shock, or heart for						ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Fin disease or condition resulting in death)	a	Due to (or as	BRAL a conseque	nce of):						
	Examiner		Sequentially list condi	itions, b.				RY DIS	EASE				
11	ured I Insit	Examiner	Sequentially list condi- if any, leading to imme cause. Enter Underlyi Cause (Disease or inju- that initiated events	ediate ing ury	Duo to (or as	a conseque	nee cty:						
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687	ficate phy s the	edical	d										
.O. Box	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							2	3d. Date of de Month	elivery Day Year	
<u>α</u>	res that signed by be deta	by	Part II. Other significa	ant conditions con		ut not result	ing in the ur	nderlying cause g	iven in Part I.				to the cause of death? Probably 4 Unknown
or Vital Records,	w require been sis	Completed								24a. Was		24b. Were a	autopsy findings available
l Re		Somp	ALI	RIAL FIBR	ILLATION					auto perfo 1∐ Yes	psy ormed? 2 1 No	death?	
Vita	ician: certific rector,	Be	25. Was case referred examiner?	T _I	lospital:		7/0-44		26. Place of Dea				
100	ding Phys I. After this funeral dii	n: To	1 Yes 2 No		28a. Date of Inju	ıry 2	R/Outpatien 28b. Time of Injury	28c. Inj	4 Li Nuising F	ome 5 Resi 28d. Describe			ecity)
Division	Attending r death. ector: After by the fune	catio	2 Accident	5 ☐ Pending investigation 6 ☐ Could not be					☐ Yes 2 ☐ No	28f Location /	Street an	d Number or F	Rural Route Number,
Div	al or Attend s after death Il Director:	Certification:	4 Homicide	determined	building, et	c. (Specify)	io, iaiiii, oti	ou, idoloty, othor		City or To	wn, State)	idia (Tobio (Tambo),
	e Hospital or 24 hours after e Funeral Direct letely filled in b	Medical C	29a. Certifier 1 (Check only 2 one)	Certifying Phys	sician: To the best ner: On the basis of and manner, st	of examination	ledge, deatl on and/or in	occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time	cause(s) , date and	and manner a place, and di	as stated. ue to the cause(s)
	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and tit	lle of certifier	+1		~		nse number		29d. Dat	1 0	nth, Day, Year)
	0		P	LA	16,	M.	D.)46356		Ju	7 13	2007
	4		30. Name and addres		•	L OSL			OWSON, M	ARYLAN	D E	1204	
D	Sta Regist	ate rar	31. Date filed (Month,	, Day, Year)	32. Registi		ire	2					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:10 PM Tuly 10 ,2007 Mengel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Doctors Hospital of Prince George's Lanham Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 X M 2 □ F 30, Lebanon, PA 62 Apr. 184-36-9810 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 TYes 2 X No Director Prince George's Greenbelt MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20770 USA 8533 Greenbelt Road, Apt. 104 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Science Systems Elementary/Secondary (0-12) College (1-4or 5+) & Applications Senior Scientist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Bender Dr. John G. Mengel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Magnolia Lane, Palmyra, PA Gladys B. Seiverling / Aunt 20b. Place of Disposition (Name of cemetery, crematory or other place) GrandView Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 7-18-07 Annville, PA 22. Name and Address of Facility Kreamer Funeral Home 21. Signat e of uneral Service License Money 618 E. Main St., Annville, 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) orcama mandl pindle Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred

certificate be executed physician and s the burial-trans as nse į P.0. the signed by t Division or Vital Records, page 2 s certificate this

Funeral

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If item 27 is marked other tha any injury or other traumatic event, the 1 once.

Physician /Medical

Examiner

Physician/Medical à Completed Be 10 Certification: filled in by the

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 ☐ Homicide

29a. Certifier

Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

9

29c. License number 0

29d. Date signed, (Month, Day, Year) 0

20704

30. Name and address of person who completed gause of d+th (Item 23a) (Type, Print) mo 74 54 E 00

30 State

Registrar

completely

After 1

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

31. Date filed (Month, Day, Year)

2007

32. Registrar's Signature

07-04862 Freddie McFadden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

J		•
State of Maryland /	Department of Health	and Mental Hygiene

reddie McFadd	1	For State Criviaryiand / Department of Health and Weritar hy Certificate of Death	rgierie Reg. I	No.	7 0010
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	Sin to the	3. Time of Death
Medical Exami		Freddie McFadden 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month Da June 26, 200	7 4c. County of Deat	
		Fort Washington Hospital Fort Washington		Prince Georg	e's
Funeral Director		5. Social Security Number ank 6. Sex 1 X M 2 F 53 Yrs. Social Security Number 1 X M 2 F 53 Yrs. Social Security Number 1 Year 1 Year 2 Hrus Min.	8. Date of Birth (N	Fore	irthplace (State or unk gin ountry)
any	-	Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b, County 10c City, Town or Location			10d. Inside City Limits
M	5	MD Prince George's Fort Washington			1 Yes 2 X No
ie Maryland or 28a-f show fied at ouce.	Director	10e. Street and Number 10219 Rolling Green Way 20744	10g.	Citizen of What Cor	untry?
vith the		10219 Rolling Green Way 20744 11. Marital Status UIIK 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-		rican Indian, Black,
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married Armed Forces? Unlk 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: Armed Forces? Unlk 1 Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:		White, etc.	black
1215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the property of the control of		b. Kind of Business	/Industry UNK
D36 thin 72 ne. than '	Completed	unk unk			
15-003 filed withi Hygiene. d other th		17. Father's Name (First, Middle, Last) unk 18.Mother's Name	(First, Middle, Main	den Surname)	unk
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route Numbe	r, City or Town, Star	te, Zip Code)
MD of 2 shot alth and in 27 is 18 aumatic		O.C.M.E. 111 Penn Street Balti		21201	
ore, ss 1 and of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	0c. Location - City o	or Town, State
Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5 X Other Specify: in state			
Baltimore, MD 212 permit. Pages I and 2 should by Department of Health and Ment Important: If item 27 is markinjury or other traumatic ever		Signature of uneral Service Licensee Leasant 22. Name and Address of Facility State Anatomy Boar Baltimore MD 212		Baltimor	e Street
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
///ed ical raminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Complicated by Hype Due to (or as a consequence of):	rthermia		Death
	ř	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of):			
scuted and transit	E	d.			
60, ate be exe hysician	Medical	UNPENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	ancy	23d. Date of delive Month	Day Year
O. Bo at the de I by the tached fi		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute (to the cause of death?
, P.O. res that the signed by be detach	d by		1 Yes	2 No 3 Pr	obably 4 Unknown
cords, P law requires t has been sign	Completed		24a. Was an autopsy	prior to	autopsy findings available o completion of cause of
Reco	E O		performe 1 V Yes 2		parameter and the second
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should b	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursin		sidence 6 Oth	ner
of Vi ing Physi After this	2	27 Manner of Death 28a Date of Injury 28b Time of Injury 22c Injury at Work?	28d. Describe how	v injury occurred	
Sion Attendin death. ctor: A	atior	2 ✓ Accident Investigation Jun 26, 2007 1000 hrs	Subject Expos Temperatures		t Environmental
Jivis Il or At after d I Direc	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, Stat	e)	Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire		29a. Certifier		réen Way, Fort V	
Divi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and mannar stated.	at the time, date an	d place, and due to	the cause(s)
F % F %	Me	29b. Signature and title of certifier 29c. License number		9d. Date signed (A	fonth, Day, Year)
		O.C.M.E.		June 27, 2007	
		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis		JUL 1 9 2007 Geren & Joseph			
DHMH 17 Rev 1/2	:001	ORIGINAL			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 45 PM Day Year Month **Physician** Miller 200 Edna 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore BALTIMORE Homewood Future Care If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year 1□M 2 F Months 90 434-18-6641 11916 maryland Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State "neturel", or Items 23e or 28e-f show digal Examiner must be notified at 1 ☑ Yes 2 ☐ No N/A Baltimore Maryland | Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 USA 718 East 37th Street Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Year or Dates: 3. Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) treumetic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be marked Linnie Bumpass (Unknown) ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an 718 East 37th St., Baltimore, MD 21218 James C. Miller (Son) Department of Health Importent: If item 27 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 7/19/07 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alhere Sclerotie Cardin Vozular Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by Plensal Elfusion 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 No 1 Yes 2 No 1 Yes Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Wursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 of this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. M 2 Accident 24 hours after death • Funerel Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 1/2001

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29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALUJA

32. Registrar's Signature

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17537

1600 W. MOZINT Reyl Ave, Balto MD 21217

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Ella C. Meadows 16:30 July 13. 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City Sinai Hospital Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2√2 F 226-28-6562 Virginia 22,1916 Director 90 Dec. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location must be notified at 1 X Yes 2 No Baltimore City N/A Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 United States Pulaski Hwy. 3639 Funeral Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Esskay Foods Meat Packer 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Naomi Lowe Valentine Horton ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21209 2131 A. Woodbox Lane Baltimore, Maryland Betty Janouris (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 7/18/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 21. Signatur of Funeral Service License 1 Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Due to or as a consequence Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 4 Pregnant at time of death signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 No Nown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 24 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 NER/Outpatient 1 Yes 2 No 3□ DOA 2 this 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury After 1 Certification: (Month, Day Year) Injury 1 I atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determine 4 Homicide

Hospital or Attending Physician: Director: / within 24 hours a To the Funeral I

> State Registra

DHMH 17 Rev 1/2001

Medical

29a, Certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of

29b. Signature and title of certifier

U

Registrar's Signature

MCAM

ath (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 State of Maryland (Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death Reg. No. 2. Date of Death 07/04/2007 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner If Under 24 Hrs 8. Date of Birth (Month, Day Birthplace (State or Foreign
Country) **Funeral M** 2□ F Min. Year) Days unknown Director of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Crisfield MD unk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or pe United States unk unk ral", or Items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White unk unk 3 Widowed 4 Divorced "natural" er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dependent Not Self Supporting unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked unk Elizabeth item 27 is marked r other traumatic e Martha ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. Calvert Street, #300, Baltimore, MD 21202 Cassandra Lucas, Social Worker 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 07/10/2007 Mt. Carmel Cemetery 4 □ Donation 5 □ Pther (Specify) 22. Name and Address of Facility 21. Signature of Funer Servic M01113 Thomas J. Skarda Funeral Home 2829 Hudson Street, Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 40 an 10.51 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) physician the burial Division or Vital Records, P.O. Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 4 Nnknown 3 ☐ Probably 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2E No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ Yes 2 No 2 ER/Outpatient 3 □ DOA = this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No If Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year, 200 / 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 St South 2120 Univ 139 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 9 1 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8, perFH, CSO, 7/25/07 TT State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 31,32,perDVR,g869,7/19/07 TTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 0 0 7 ear **Physician** July 15, 3:50 P M John Mostris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Kingsville 2521 Karylou Drive Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 M 2 □ F 49 216-72-7445 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notlfied at 10a. State 1 ☐ Yes 2 No Director MD Harford Kingsville 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number "natural", or items 23a or dical Examiner must be r 21087 USA 2521 Karylou Drive Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23, Iry or other traumatic event, the Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: White 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Mostris Chrisanthe Lemonakis 19a. Informant's Name/Relationship (Type. Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing 2521 Aristea Mostris - Wife Karylou Dr., Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 7-18-07 Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral Service Licenses 2134 Willow Spring Road, 21222 PA, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 → 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩o 2 ER/Outpatient 3 DOA ို 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ..
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 0023519 Belan Rd. Fallston, und 21047 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2303 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 19 Registrar

DHMH 17 Rev 1/2001

			For	State	of Marylan		artment of H		and Me	ntal Hy	gien	е	
			1 - State Registrar			Ce	rtificate of	Death			Reg. N	o	20193
	Physicia	an	1. Decedent's Name (First, Middle,	,	Tae				2.	Date of De Month July	ath	2007 Year	3: Time of Death
	/Medic		Charles Henry F 4a. Facility Name (If not institution,				4b. City, Town, o	r Location o		July		c. County of Deatl	11:30a M
C.	Examin	ier	2700 Wilkens Ave				Baltimo					N/A	
Е	Funeral		5. Social Security Number 6	. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Min.	Date of Birl	th	0 Rint	nplace (State or Foreign
	Director		214-44-8865	M 2□F	61_	Yrs.	World B Days	Hours	S	ep. 2	8,	1945 M	aryland
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Man	-f sh	tor	MD				Baltin	nore					1 X Yes 2 □ No
d d d	or 28a	Director	10e. Street and Number				10f. Zip Code				10g. C	Citizen of What Co	untry?
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ar de	items ner m	Funeral	11. Marital Status	Armed F	cedent Ever in U Forces?	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Specif n, Puerto Ric	y Yes or No can, etc.))-	14. Race - Amer Black, White	
DOSO Polite aff	Ir, or xami	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	If Yes, G			1□Yes 🛣 No	Specify:				Specify:	√hite
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d be file	red of	o Be	Charles Henry P	′	Sr.				•			enhack	
ary shoul	mark mark	은	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street						ip Code)
Man	alth a 127 is er trat		Charlotte Sulli	van - Si	ister	1252	Vogt Ave	enue,	Arbut	us, M	D 21	1227	
	of He		20a. Method of Disposition 1☑ Burial 2 ☐ Cremation 3	R D Bemoval from	- Ct-t- 1	cemetery, crei	sition (Name of matory or other pla	ce)	Date			Location - City or	*
DAILITION	tant; I		4Donation 5 ☐ Other (Spe	ecify)	Cec		ll Cemete		-18-20	007	Bro	oklyn Pa	rk, Marylan
Dan Dan	popular pegodation of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service Li	densee	2 a Tinc		2. Name and Addre lbrose Fue 28 Sulphi	enral	Home.	Inc.	27		
16	93/3		23a. Part1. Enter the disease, or co shock, or heart failure. List of	omplications that	caused the deat	h. Do not ent	er the mode of dyin	ng, such as	cardiac or re	espiratory a	rrest,		Approximate Interval Between
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٧ .	*	-E	Sequentially list conditions,	b	o (or as a conseq	uence of):							
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The law requires that the death certificate be executed	physician and s the burial-transit	dical		d									
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DOX	attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf pregna birth 2 Feta gnant at time of c	aldéath 3∐	☐Ectopic pregnanc	y				23d. Date of deli Month	very Day Year
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s that	ned b		Part II. Other significant condition	s contributing to	death but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did t	obacco	use contribute to	the cause of death?
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Sion Of	th. ; Afte e fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mo	onth, Day Year)	injury	Wor	k? Yes 2∐I		1. DOSONDO 1		ary coounica	
Affer V	er dea rector by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Plac	ce of injury - At he	L ome, farm, str fv)	eet, factory, office		28f	Location (S	Street 8	and Number or Ru	ral Route Number,
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DIVISION OF VICE	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier Certifying (Check only one) 2 Medical Ex	caminer: On the	ne best of my kno basis of examina Inner stated.	owledge, deat ation and/or in	h occurred at the till vestigation, in my o	me, date an opinion, dea	nd place, and ath occurred	d due to the at the time,	cause(date a	(s) and manner as and place, and due	stated. to the cause(s)
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	withir To th	Me	29b. Signature and title of certifier				29c. Licens	e number			29d. D	ate signed (Month	n, Day, Year)
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6	$^{\prime}$ \emptyset		30. Name and address of person w		use of death (Item		Print) Ton Aug	enrie	Bas	Himo	re/	ND ZIZ	29
	Sta	_	31. Date filed (Month, Day, Year)	32	Registrar's Signa								·
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Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at FNOUN AS MARCUS William Pack
Baltimore, Maryland 21215-0036 KNOWN WY **Physician** /Medical **Examiner** the attending physician and Division or Vital Records, P.O. Box 68760, as the i signed by the a ld be detached f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 508 Marcus William Pack M 2∞ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Sultimore 8. Date of Birth June 12, 2006 5. Social Security Number 9. Birthplace (State or Foreign Sex 1M 2□F Days Hours Maryland 218-75-3256 1 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2√√No Director Maryland Middle River Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 13 Pocasset Court USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ William Pack Alicia Bolden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Pack (mother) 13 Pocasset Court, Middle River, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grd: 07/20/2007 Timonium, Maryland 21. Signatur of Funeral S 22. Name and Address of Facility Ruck Towson Funeral Home , Inc. 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (o as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Figure that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manifier stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 38127 30. Name and address of person who complete tell se of death (Item 23a) (Type, Print)

State Registrar Day Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 316pm **Physician** 2007 1014 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Months Days 28, 1954 United Kingdom 53 Feb. Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan attrent of Health and Mental Hygiene. Ordent: If femer 27 is marked other than "natural; or Items 23a or 28a-1 show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 United Kingdom 6429 Grateful Heart Gate Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Government Worker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If them 27 is marked o any injury or other traumaitr Jean Lila Gardner ပ Thomas Harry Gray 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3100 Massachusetts Ave. NW British Embassy Rm.422 Washington, DC 20008 19a. Informant's Name/Relationship (Type. Print) Julia MacGregor (Co-Worker) 20b. Place of Disposition (Name of cempetery, ctematory or other place)
Cheltenham
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Cheltenham England 1 Burial 2 □ Cremation 3 □ Removal from State 7-24-07 4 ☐ Donation 5 ☐ Other (Specify) 23 Name and Address of Facility Rowland Frothers International Surrey, England CRO 2HR 21. Signature of Funeral Service License tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eause on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician MINUTES /Medical Examiner phage 41 50 Sequentially list conditions, if any, leading to finine list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) igned by the a 9□Unknown 9 X Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Matural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

executed es that the death certificate be

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to the Hospital of Attending Physician: The law requir		To the Funeral Director: After this certificate has been s	completely filled in by the funeral director, page 2 should
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29a. Certifier (Check only one)

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30. Name	and addres	s of persor	who comp	oleted caus
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29b. Signature and title of certified

1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

17,2007

e of death (Item 23a) (Type, Print)

Columbia, Mil 21044 CEUAR JON DER (IN, MD

31. Date filed (Month, Day, Year) JUL 1 9 2007

32. Rigistrar's Signature

07-04795

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

Revin M. Person	_	epartment of Health and Mental Hy Certificate of Death	Reg. No. 2007 2319				
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year 0810 hrs				
†	Kevin M. Person 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	June 24, 2007 08:10 nrs 4c. County of Death				
	901 South Bond Street	Baltimore					
Funeral Director	1 X M 2 F	yrs. last birthday) 41 Yrs. If Under 1 Year If Under 24Hrs Months Days Hours Min.	May 22, 1966				
., v.	Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Location	10d. Inside City Limits				
Aaryland 28a-f show 1 at once.	MD	Baltimore	1 X Yes 2 No				
a or tiffer Dir	10e. Street and Number 514 Cathedral Street	10f. Zip Code 21201	10g. Citizen of What Country? USA				
or items 23		unk No If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, etc.				
after	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed in the second of the second o	1 Yes 2 X No specify: ted) 16a. Decedent's Usual Occupation (Give kind of v	Specify: black work domenk 16b. Kind of Business/Industry unk				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by F	Elementary/Secondary (0-12) College (1-4 or 5+) unk unk	during most of working life. DO NOT use reti					
215-0036 be filed within 7 that Hygiene. rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	e (First, Middle, Maiden Surname) unk				
2121 Duld be fi Mental I marked ic event,	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)				
MD and 2 shot alth and m 27 is:	O.C.M.E.	111 Penn Street Bal	timore, MD 21201				
ore, es and of Heal If item	20a. Method of Disposition Burial 2 Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State				
Baltimore, permit. Pages I ar Department of Hee Important: If ite	4 Donation 5 X Other Specify: in state	, 22. Name and Address of Facility					
Depression of the property of	Anthony Plea ant	Raltimore MD 21	rd 655 W. Baltimore Street				
Physician /Medical	23a. Part I. Enter the disease or complications that caused the failure. List only one cause on each line.	death. Do not enter the mode of dying, such as cardiac of	or respiratory arrest, shock, or heart Approximate Interval Between Onest and				
caminer	Immediate Cause (Final disease or condition resulting in death) a. Drowning compound to form the condition of the condition	<u>licated by acute alcohol intoxicence of):</u>	eation				
	Sequentially list conditions, b						
red nsit Examiner	if any looding to immediate cause. Enter Underlying Cause (Disease or injury that initiated	nnos orp					
nted id ansit	events resulting in death) Last Due to (or as a consequence of): d.						
oe exectician articial - tr	XUNPENDED AMENDED 7,28a-	f, perME,G869, 7/20/07 TT					
3760, ificate be g physic s the burn	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		23d. Date of delivery ancy Month Day Year				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Ex	past 12 months? 1 Yes 2 No 9 Unknown	2					
D. B. true de by the ached f		it not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?				
ires that signed libe deta			1 Yes 2 No 3 Probably 4 V Unknown				
Records, The law requires ficate has been sig , page 2 should be Completed			24a. Was an 24b. Were autopsy findings available 24b. prior to completion of cause of				
Reco			performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No				
ician: s certifi	25. Was case referred to medical	26.Place of Death (Check 2 ER/Outpatient 3 DOA Other Nursi	only one) ng Home 5 Residence 6 ✔ Other: Scene				
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lending sath.	1 Natural 5 Pending Fnd 6/24/20	1 Voc 2 V No	unk				
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director, endical Certification: To Be (2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury	- At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Dospital hours uneral ly filled		nd in harbor nowledge, death occurred at the time, date and place, an	901 S. Bond St. Baltimore, MD				
To the Ho within 24 To the Fu complete!	(Check only one) 2 Medical Examiner: On the basis of examin and manner stated.	ation and/or investigation, in my opinion, death occurred					
To T	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
	Patrilliani - Pol	ll n O.C.M.E.	June 24, 2007				
	30. Name and address of person who completed cause of deal Patricia Aronica-Pollak MD. Assistant Med	h (Item 23a) Jical Examiner 111 Penn Street, Baltimo	re, MD 21201				
State							
Registra	JUL I O 2001 July	S. Books					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

07-04990 Roland Payton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

oland Payton		State of Maryland / Department of Health and Mental For State Certificate of Death	Reg. N	10. 2Û	17 2319
Physician		eqistrar . Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death 1426 hrs
ledical Examine	ī	Roland Payton	June 30, 200	7 4c. County of Death	
Ž.	4	a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 1721 Braddish Avenue Baltimore	tn	4c. County of Death	'
Funeral	5	Social Security Number unk6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H		M/DD/YYYY) 9. Bir Foreig	thplace (State orunk
Director		1X M 2 F 83 Yrs. Months Days Hours M	June 13,	1924 Co	untry)
	_	Isual Residence of Decedent 10c. City, Town or Location			10d. Inside City Limits
w an	1	0a. State 10b. County 10c. City, Town or Location MD Baltimore			1 X Yes 2 No
aryland 8a-f show any at once.		0e. Street and Number 10f. Zip Code	10g.	Citizen of What Cou	ntry?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Esaminer must be notified at once.	<u> </u>	1721 Braddish Avenue 21216		USA	
or items 23	e la	11. Marital Status UNK 12. Was Decedent Ever in U.Sun (13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
or death		1 Never Married 1 Yes 2 No		Specify:	black
irs afte	ବ}-	Lor Dates: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of the complete of th	THE PARTY OF THE P	6b. Kind of Business	
136 hin 72 hours a e. than "natura edical E. ami		Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use r	etired)		
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21215-0036 uld be fited within 72 hours Mental Hygiene. marked other than "natur	3 8	17. Father's Name (First, Middle, Last) UNK 18. Mother's Na			UIIK
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Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	ic or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
M dical	1	Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease			Death
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	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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Box 68760, e death certificate be the attending physic edfor use as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre	egnancy	Month	Day Year
ox 6 sath cer attendi	Physician/N	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown		1	
D. B.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
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tal Recoleran: The law certificate has ector, page 2 sl	Completed		1 Yes 2		Yes 2 No
tal F	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other;4 No.		tesidence 6 🗸 Ot	her: Scene
Division of Vital Records, P.O. B pital or Attending Physician: The law requires that the d ours after death. reral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached	۵	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA No. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		ow injury occurred	
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Visic or Atte fler des Directo	iţica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
Div spital of cours al	Certification:	4 Homicide determined (Specify)		(-)	totod
Fu Fu		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, death occurred at the time, date and death occurred at the time, date at the time, da	, and due to the cause red at the time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (
		Marinte me Soul O.C.M.E.		July 1, 2007	
		30. Name and address of person who completed cause of death (Item 23a)	MD 21201		
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	VID 2 1201		
Sta Regist	ate	IIII I I IIII I PROGRAM IN CORNEL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #17,perFH,g879 5/14/08 TT Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 ROGERS Year 200 **Physician** 05 M GARDNER 101 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clen Burnie If Under 1 Year If Under 24 Hrs. 1132 Nottingham Drive Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 10 M 2□F Director Aug 10, 1929 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show t be notified at 1 TYes 2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a of the Medical Examiner must b USA by Funeral 1132 Nottingham Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No MYes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify. White Baltimore, Maryland 21215-0036 1 ☐ Yes ŽŽ No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Intelligence permit. Pages 1 and 2 should be filed be partiment of Health and Mental Hygid Important: If item 27 Is marked other any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elliott Gardner Rogers Lillian J. Fleming 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1132 Nottingham Drive, Glen Burnie, MD 21061 Hilde Rogers Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory July 17, 2007 Baltimore, MD 4 Donation 5 Other (Specify 21. Sign veo Funeral Service Lig 22. Name and Address of Facility Fink Funeral Home, P.A. uregor Fine 426 Crain Hwy S, Glen Burnie, MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest price cause on each line. Enter the disease, or or heart failure. List Approximate Interval Between Onset and Death 23a. Part Immediate use (Final disease or contition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of): Box 68760, physician pe Physician/Medical the as IF FEMALE: nse s If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9□Unknown 9 Unknown ate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3Æ Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 252 No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie W HIGHWAY ANNAPOLIS MD21401 30. Name and address of person who confideted cause of death (Item 23a) (Type, Print) ENSE ENT NA ms 445 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 1 9 2007 Registrar

DHMH 17 Rev 1/2001

07-05446 Bria

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

an Rubin	1	State of Maryland / Depa	rtment of tificate of		and I	Menta	I Hygie		g. No.	26	107 23	
Physicia	R	egistrar . Decedent's Name (First, Middle,Last)	imodio oi					ate of Deat	h		3. Time of Death	7
Pnysicia edical Examin	-	Brian John Rubin						onth Ily 15, 20	Day 007	Year	2250 hrs	
	•	a. Facility Name (if not institution, give street and number)	4	b. City, Tov		cation of E	Death		4c. Co	unty of Death		1
		3100 Gibbons Avenue		Baltimo		16111 0	0411an 10 1	Data of Pir	th/MM/DDC	N/A	thplace (State or	4
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. Ia		If Under Months	_	If Under 2 Hours	Min.			Foreig	gn	١
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uryland	황	10e. Street and Number	20111010	10f. Zip C	ode			1	0g. Citizen	of What Cou	intry?	٦
after death with the Maryland "al", or items 23a or 28a-f show any iner must be notified at once,	Director	3100 Gibbons Avenue		21:	214					USA _		╛
with t		11. Marital Status 12. Was Decedent Ever in U.	S. 13. Wa	s Decedent	of Hispa	anic Origin Mexican, P	? (Specify	Yes or No	14.	Race - Amer White, etc.	rican Indian, Black,	
death or iten	Ë	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No			-			,,	0	T71		١
after	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	16a. Deceden	Yes 2	_		nd of work	done		ecify: What of Business	nite	┨
hours 'natur	E e	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during m	ost of worki	ng life. D	O NOT us	se retired)		Reno	vation	n &	1
36 nin 72 than than	ed	2	Carpe	nter					Remo	deling	3	
d with	Completed	17. Father's Name (First, Middle, Last)			18	3.Mother's	Name (Fir	st, Middle,	Maiden Sui	mame)		٦
AD 21215-0036 2 should be filed within 72 hours after de h and Mental Hygiene 27 is marked other than "natural", or matic event, the Medical Examiner m	Be (Stanley Rubin		A 200		She	ila	Wyli	e	- 0:	7 0 11	4
21 nould lid Men is man	٩	19a. Informant's Name/Relationship (Type, Print)	1							or Town, Stat		1
e, MD 21215 1 and 2 should be file Health and Mental H item 27 is marked or r traumatic event, I		Kristen King – wife 20a. Method of Disposition 20b.	3100 Place of Dispos	Gibb sition (Name	ons of ceme	Avenu	ue, B	altin ate	20c. Loc	MD 21 cation - City o	or Town, State	٦
or Hear tr		1 Burial 2 X Cremation 3 Removal from State	crematory or ot	her place)			1	•••				
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Baltimore, MC permit. Pages 1 and 2 st Department of Health at Important: If item 27 injury or other trauma	ŀ	21. Signature of Funeral Service Licensee Williams	22.	Crema 299 F	ion	Soci	lety (of Ma	rylan	d, Inc		
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Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Contact Gunshot Would a. Contact Gunshot Wo									Death	
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Box 6876C death certificate the attending physel for use as the b	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pre		etal death	3	Ectopic	pregnancy	1		onth	Day Year	
× 6. th cert trendir	icia	past 12 months?	eath 5 C	ther (Spec	ify)							
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OFC aw re has be 2 shor	ıρle							per	opsy formed?	death'		
tal Rec	Completed by				e Place	of Death ((Check onl		2No	1 🗸	Yes 2 No	_
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by ectabase	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At	home, farm, str	eet, factory	office b	uilding, et	c. 28	3f. Location	(Street and	d Number or	Rural Route Number, Cit	ty
Divisi sepital or Att hours after d meral Direct	Certification:	4 Homicide determined (Specify) Multi-Fan					-			e, Baltimore		
Hosp 24 hor Fune stely fi		29a. Certifier 1 Certifying Physician: To the best of my knowle	dge, death occ	urred at the	time, da	ate and pla	ace, and du	ue to the ca	use(s) and	manner as s	tated.	
Divi To the Hospital or. within 24 hours after To the Funeral Dir	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investig			e number	our ou at ti	unie, da			Month, Day, Year)	_
	Ž	29b. Signature and title of certifier		290		M.E. ^{OC}	ME			16, 2007		
		Thurson U. K. ATALLE	M.		U.U.I		_					_
10		30. Name and address of person who completed ใจเรื่อ of death (lte Theodore M. King, Jr., MD. Assistant Medical		111 Pe	enn Str	reet, Ba	Itimore,	MD 212	01			
V	<u></u>	31 Date filed (Month Day Year) 32. Registrar's Signal		0								_

Registrar

98

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2**X** No If Yes, Give Year or Dates:

10c. City, Town or Location

Baltimore

10f. Zip Code

1 ☐ Yes 2**X** No

21209

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.)

06, 1908

10g. Citizen of What Country?

United States of America

Race - American Indian, Black, White, etc.

Specify: White

Virginia

10d. Inside City Limits

Y Yes 2 No

November

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

Director

Director

Funeral

d by

215-09-8413

Maryland

11. Marital Status

10e. Street and Number

Usual Residence of Decedent

10b. County

2411 Crest Road

1 Never Married 2 Married

3 Widowed 4 □ Divorced

Physiciar /Medica Examine

Division or Vital Records, P.O. Box 68760,

5	Elementary/Secondary (0-12)	College (1-4or 5+) 4 ±	`life. DO NOT use i	•	Q Q	etail					
e Complete	17. Father's Name (First, Middle, Last)	·	Tersonn		ne (First, Middle, Maid						
Be C	James Sturgis Hundley Almeda Ann Clarke										
2	19a. Informant's Name/Relationship (T	-	10h Mailing Address (S			y or Town, State, Zip Code)					
	Joanne Cosden	(Daughter)			-	, Maryland 21133					
			<u> </u>								
	20a. Method of Disposition 1 XBurial 2 Cremation 3	C	lace of Disposition (Name emetery, crematory or othe	r place)		Location - City or Town, State					
	4 Donation 5 Dother (Specify) Smit!	hland Baptis			thsville, VA 224					
	21. Signature of Funeral Service Licens	see				Funeral Director					
	rolah		8728 L1b	erty Road,	Randallsto	wn, Maryland 211					
	23a. Part1. Enter the desease, or comp	olications that caused the death	. Do not enter the mode of	f dying, such as cardiac	or respiratory arrest,	Approximate					
	shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	(11.0	Concer		Interval Betwee Onset and De					
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	resulting in death) Last Due to (or as a consequence of):										
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Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal	ncy death 3⊟Ectopic preg			23d. Date of delivery					
cial	in the past 12 months?		Month Day Ye								
ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown										
유	Part II. Other significant conditions co	o use contribute to the cause of dea									
þ	Azz	2☐No 3☐ Probably 4☐Un									
Completed		25.10 05.1105.00)									
를		24a. Was an autopsy	24b. Were autopsy findings av prior to completion of cau								
DO.	A	ypertension			performed 1 Yes 2 1	death?					
Be C	25. Was case referred to medical	1 -		26. Place of Dea	ath (Check only one)						
To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ DOA	Other	lome 5 Residence	6 □Other (Specify)					
F	27. Manner of Death	28a. Date of Injury		Injury at Work?	28d. Describe how in						
1 ::	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No							
tion:	Z C Accident				28f Location (Street	and Number or Rural Route Number					
ication:	3 ☐ Suicide 6 ☐ Could not be	3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locati									
ertification:		building, etc. (Specify	Ö								
Certification:	4 Homicide determined			the time det							
ical Certification:	4 Homicide determined	ysician: To the best of my kno- niner: On the basis of examina	wledge, death occurred at	the time, date and place my opinion, death occu	le, and due to the cause arred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)					
edical	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying Phyone)	ysician: To the best of my kno	wledge, death occurred at tion and/or investigation, in	my opinion, death occu	urred at the time, date a	and place, and due to the cause(s)					
Medical Certification:	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying Phyone)	ysician: To the best of my knominer: On the basis of examination and manner stated.	wledge, death occurred at tion and/or investigation, ir 29c. L	my opinion, death occu	urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)					
edical	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying Phyone)	ysician: To the best of my kno- niner: On the basis of examina	wledge, death occurred at tion and/or investigation, ir 29c. L	my opinion, death occu	urred at the time, date a	and place, and due to the cause(s)					
edical	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	ysician: To the best of my kno- niner: On the basis of examina- and manner stated.	wledge, death occurred at tion and/or investigation, in 29c. L	icense number	urred at the time, date a	Date signed (Month, Day, Year)					
edical	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying Phyone)	ysician: To the best of my kno- niner: On the basis of examinat and manner stated.	wledge, death occurred at tion and/or investigation, in 29c. L	icense number	urred at the time, date a	Date signed (Month, Day, Year)					
edical	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	ysician: To the best of my kno- niner: On the basis of examina- and manner stated.	wledge, death occurred at tion and/or investigation, in 29c. L 23a) (Type, Print)	icense number	urred at the time, date a	Date signed (Month, Day, Year)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** FOCE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner 5. Social Security Number If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 □ M 2 🛛 F 215-76-0006 7/09/1920 87 Director SC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State 1 ☐ Yes 2 X No Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 803 Dale Road U.S.A. 21060 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 🖾 No Specify white Specify: 2 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Home Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bonner L. Haddon ဥ Annie Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Roy E. Rapp, Jr. / son 311 Luther Road; Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 07/19/2007 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si na Tro of Emeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home, PA 7013 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) - mis /Medical Due to a consequence of): Examiner 6-4 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2★No 24a. Was an autopsy perform 20 No 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2500 1 epatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury

Box 68760. P.0. Division or Vital Records,

death certificate be executed and use as the burial-trar attending physician ò signed by the a page 2 certificate Physician: director this funeral After

r 28a-f show notified at

h and Mental Hygiene. 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r

72 hours after

filed within 7 I Hygiene.

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun

Baltimore, Maryland 21215-0036

Certification:

2 Accident

4 ☐ Homicide

3 Suicide

6 Could not be determined

Hospital or Attendi
 24 hours after death.
 Funeral Director: A etely filled in by the fu

within 24 hours at

State Registrar

Medical

29a. Certifier (Check only one)	the continuing the co	death occurred at the time, date and place, and due to l/or investigation, in my opinion, death occurred at the til	the cause(s) and manner as stated. me, date and place, and due to the cause(s
29b. Signature and lit	tle of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1/6	MA	17512	July 16 2007
30. Name and addres	ss of person who completed cause of death (Item 23a) (T	ype, Print)	~
DAVID CHE	SIEL 22 5. Green St.	Baltimon Mr 21201	
31. Date filed (Month.	Day, Year) 32. Registrar's Signature.	A	

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland / Dep Ce	partment of Health and Nertificate of Death	lental Hygien	211117	23202
	Physici		1. Decedent's Name (First, Middle, Last)	ROBE	RSON	2. Date of Death Month	ay th 2007	3. Time of Death 4. 30 A M
	/Medic Examin		4a. Facility Name (If not institution, give s	Nursing Center	4b. City, Town, or Location of Death	4	c. County of Death	
	Funeral Director		5 Social Security Number 6. Sex		y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 0+03 19	9. Birthol Count	ace (State or Foreign ry)
	aryland ahow	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I		• •	10	od. Inside City Limits
	ith the Ma or 28a-f	Funeral Director	Mb Battin 10e. Street and Number		101. Zip Code	10g. C	Citizen of What Count	
	r death w	neral	145 Browning	P. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Pueric	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
9036	ours after rrat', or it	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 KNo Specify:		Specify: Bla	
21215-0036	ilied within 72 hours after death with the Maryland Hygiene. the than Insturat', or ttema 23a or 28a-f ahow ent, the Madisal Examirate must be motified at	Completed	15. Decedent's Edu (Specify only highest grade	completed) College (1-4or 5+) College (1-4or 5+)	redent's Usual Occupation ve kind of work done during most of work . DO NOT use retired) Howekeeper	ing 16b.	Pri Vat	•
and 2	i be filed with ntal Hygiene ed other tha event, tha	Be	12th, grade 17. Father's Name (First, Middle, Last) Pagin 10 100 100 100 100 100 100 100 100 100	19/4	18. Mother's Nam	e (First, Middle, Maide Bailee	en Sumame)	
Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar Department of Heelth and Mental Hygiene. Importants of Hema 23a or 28a-f show Importants if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Medical Example actions be confilled at Once.	으	Ben amu Hall 19a Info ant's Name/Relationship (Ty	Doe, Print) 19b. Mai Daughter 145	iling Address (Street and Number or Run	al Route Number, City	1	
	Pages 1 end nent of Heelth int: If Item 27 iry or other tr		Barbara Holland/ 20a. Method of Disposition 1 Burial 2 Cremation 3 🗆 R	20b. Place of Discometery, cr	position (Name of rematory or other place)	Date 20c.	Location - City or To	wn, State
Baltimore,	permit. Pag Department Important: any Injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensu		nily Cemetory 07/2 22. Time and Address of acility Va 4905 York Road Bo	ughn C. Gr	eene Filme	ralsucs
	10200		shock, or heart failure. List only or	cations that caused the death. Do not e			1400 2122	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	3	1 -	0	2 weeks
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	CSEDL				
,160,	te be executed ysicien and e burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last					
89	artificate b ing physic e as the b	Medical	IF FEMALE:					
O. Box	irres that the death certificete be executed signed by the attending physicien and d be detached for use as the burial-transit	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes		B Ectopic pregnancy Discrete (specify)		23d. Date of delive Month	ry Day Year
ds, P.O.	The law requires that the death certifice ate hes been signed by the attending progge 2 should be detached for use as it		Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacci	o use contribute to th	M
Division of Vital Records,	The law requir te hes been si ege 2 should I	Completed				24a. Was an autopsy performed	prior to cor death?	osy findings available inpletion of cause of 2 MNo
Vital	Physician: This certifice ral director, p	Be	25. Was case referred to medical examiner?	lospital:		th (Check only one)		
n of	ing Phys After this uneral dir	lon: To	27. Manner of Death	28a. Date of Injury (Month, Day Year) 2 ■ ER/Outpati	of 28c. Injury at	ome 5 Residence 28d. Describe how in		"
ivisio	or Attending fler death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street City or Town, Str	and Number or Rura ate)	l Route Number,
	To the Hospital or Attending Physician: The lav within 24 hours elfer death. To the Funeral Director: Affer this certificete hes completely filled in by the funeral director, page 2	Medical Ce		sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.				
	To the within 2 To the comple	Med	29b. Signature and title of centrier	Turpua	29c. License number		Date signed (Month.)	9ay, Year) 7 200 7
•	2		30. Name and address of person who co	impleted cause of leath (Item 23a) (Typ	- D3066/	Md-21°	239.	
ė	Sta Regist		31. Date filed (Month, Day, Year)	\$2. Registrar's Signature				

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 20b, perFH, 0869, 7/27/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** lae. 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If lot institution, give street and number) Examiner HOSPITAL TIMOR AGNES Date of Birth (Month, Day If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ 61 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 Pes 2 No ral", or items 23a or 28a-f sl Examiner must be notified Funeral Director 10g. Citizen of What Country? 10f, Zip Code . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural;" or iten
Inty or other traumatic event, the Medical Examiner
Inty or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ife: 90 NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) To Be Department of Health a Important: If item 27 is any Injury or other trains (daughter) 20a. Method of Disposition 1 Durial 2 □ Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service icensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumothorax Physician nours /Medical Due to (or as a consequence of) Examiner mon ary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? To Be Completed by Vital Records, 3 Probably 4 Monknown 2□ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) Division or 27. Manner of Death Date of Injury 28c. Injury at Work? Time of 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INDER

32. Registrar's Signature

ORIGINAL

State Registrar SAVOHV A 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

		Registrar			Certific	ate of	Death	1		Reg. No.	200	1 2	120	
Physicia		Decedent's Name (First, Middle Market		Schweig	er				2. Date of De Month JULY	Day	Year 2007	3. Time of 03:50		
/Medica Examine	4. Cit. Town and profile of Double									4c. County of Death BALTIMORE				
Funeral Director		5. Social Security Number 214–38–6096	404 000	e (In yrs. last bi 66	Yrs. If U	nder 1 Year ths Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da 12/05/	th ay, <i>Year)</i> 1940	9. Birth Cou MD	place (State o	or Foreig	
yland now at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside Ci	ity Limits	
the Mar 28a-f sh notified	Director	DE 10e. Street and Number	Sussex		Long	Neck Zip Code				10g Citizer	of What Cou	1 ☐ Yes	2 X No	
3a or		32843 Landlubl	oer Cove			19966	5			USA		,		
al", o	ed by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced 15. Decedent	If Yes, Give Year or Dates:	lo	If Yes,	specify Cuba	an, Mexica Specify	an, Puerto I	cify Yes or No Rican, etc.)	Yes or No- un, etc.) 14. Race - American Indian Black, White, etc. Specify: White				
within 72 iene. r than "na the Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)			ive kind of work done during most of working e. DO NOT use retired) Homemaker					16b. Kind of Business/Industry Domestic			
nd Mental Hygi marked other imatic event, the	To Be C	17. Father's Name (<i>First, Middle,</i>	*	wski				_	(First, Middle		rname)			
Ith and M		19a. Informant's Name/Relationsh Mrs. Laura Szcz		stor					l Route Numb			o Code)		
permit. Tages I and 2 should be permit. Tages I and 2 should be Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		20b. Place o	of Disposition ery, crematory	(Name of or other plac	ce)	D	nster, ate /2007	20c. Locat	ion - City or T	50		
Departm Departm Importa any inju		21. Signature of Funeral Service Paige Haigh	_{Licensee} nt Hebert per		22. Nam	e and Addre	ss of Faci	lity 1 Hom	e & Cha					
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	e. LV CI (C) a consequence	not enter the of):	ow	ig, such a	s cardiac o	r respiratory a	rrest,		Approximate Interval Bet Onset and I	tween Death	
E B	iner	Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Dim to (ur as t				- 1					4 8	0095	
	dical Examiner	that initiated events resulting in death) Last		NEUMENIA - post-op a consequence of): @SYNC ONT/EX obstructic							zuhs			
been signed by the attending physishould be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome particle 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)					23d. Date of delivery Month Day		Year		
igne be c	ò	Part II. Other significant condition	ns contributing to death bu	t not resulting i	n the underlyi	ng cause give	en in Part	I.	23e. Did 1		contribute to t			
2 2 2	Completed								24a. Was auto perfo 1□ Yes	an 2 psy prmed? 2 No	24b. Were autoprior to codeath? 1 ☐ Yes		available ause of	
this certificated director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatier	nt 2 ☐ ER/O	utpatient 3	DOA Oth	or:		<i>(Check only o</i> ne 5 ☐ Resi		Other (Speci	60		
To the Tropical or Adentity Prystorial. The Within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation	y Year) 28b.	Time of Injury M	28c. Injur Worl]No	28d. Describe	how injury o	ccurred		phor	
spiral or violate of the control of		4 ☐ Homicide determi	g Physician: To the best of	of my knowledg	e, death occu	rred at the tir	me, date a	and place.	City or To	wn, State)	d manner as	stated		
To the Hospital Within 24 hours and To the Funeral completely filled	Medical	(Check only one) 2 ☐ Medical one) 29b. Signature and title of certifier	Examiner: On the basis of and manner sta	examination at	nd/or investig	ation, in my o	pinion, de	eath occurr	ed at the time	, date and pl	ace, and due i	to the cause(s	3)	
	_	30. Name and address of person	who completed tause of de	M)	(Type Print)	73	cyza	ک 		7/	1867	,		
10-		South Fre	mio complete deadse of de	cru (23a)	(Type, Pilit)							21200		

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	Amend Items 2	3a,Pt11,25,27	,28a-r Cer	tificate of l	Death 1	ZI/O/dhb.	Reg. No.	07 23206			
Division	1. Decedent's Name (First, Middle, La	st)				2. Date of De	eth Dey	3. Time of Death			
Physician /Medical	Edward G. Schro	eder		10, 2007							
Examiner	4a Fecility Name (If not institution, give	or Location of Deet									
		ton Conv & Rehab Center Crofton With Number 6 Sax 7 Ane (In vrs. last hithday) If Under 1 Year If Under 24 Hrs.						Arundel			
Funeral Director	5. Social Security Number 6. 8 488-09-6438	9. Birthplace (State or Foreign Country) Missouri									
70	Usuel Residence of Decedent						5, 1910				
nylen show	10a. State 10b. County	10c. C	ity, Town or Loc		011	•		10d. Inside City Limits			
Se-fs	MD Anne Art	ındel -	Crofto	Ti -	Gambril			1 ☐ Yes 2√ No			
1215-0020 within 72 hours after death with the Meryland ene. than "natural; or items 23e or 28e-1 show ite Medicel Examiner must be notified at impleted by Funeral Director	10e. Street end Number 730	Rt.3 South		10f. Zip Code	21054 - 21114	+	10g. Citizen of What Country? USA				
of the death of the transport of the tra	11. Marital Status	12. Was Decedent Ever in t Armed Forces?	J,S. 13. W	as Decedent of Hi	ispanic Origin?	(Specify Yes or No uerto Rican, etc.)	o- 14. Race	e - American Indian, ck, White, etc.			
21215-0020 d within 72 hours afte giene. r than *natural*, or it in Medical Examin Completed by Fu	1 ☐ Never Merried	1 AYes 2 No			Specify:	,		white			
1 21215-0 9 ygiene. Her than 'natura H, the Medical.	15. Decedent's Ed (Specify only highest gre	ducation de completed)	(Give k	ent's Usual Occupa	during most of t	working	16b. Kind of Bu	usiness/Industry			
In	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	1)		Anhaus	er Busch			
CA DEPT N	12	0		painter	40 Math and A	Mana (Fina Adiddi	1	erovements			
E 8992 0	17. Father's Name (First, Middle, Last,					_{Name (First, Middle} esa Victo	•				
ryla hould I a Meni merke metic	George John Schro		10h Mailine	Addrson /Ctrost		Rurel Route Numb					
Mand 2 s th an th an traus	Rita M. Fullem/d	** '				rofton, M					
s 1 en f Heal	20a. Method of Disposition	20b.	Place of Dispos			Date	20c. Location -	City or Town, State			
imo Pege nento ant: if ury or	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specif	Hemoval from State	cemetery, crem	atory or other plac	:6)						
Baltin permit. Pe Depertmen Important: any injury	21. Signature of Funeral Service Licer Anthony D		1 0.			ard 655 W .201	. Baltim	ore Street			
A	23a. Part1. Enter the disease, or com	plications that caused the dea		1timore,			rrest	Approximate			
Physician	shock, or heart failure. List only	one cause on each line.				Y		Onset and Death			
/Medical	Immediate Ceuse (Final disease or condition	P. as		^ ^	1/1	1	- AMINE!	well >			
Examiner	resulting in death)	a. Due to (or es a consequ	ence of):	49	hL w	EDICAL EDV	years			
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x 68760, ertificete be executed ling physician end ee st he buriel-transit Medical Examiner	Sequentially list conditions, if env, leading to immediate cause. Enter Underlying Cause (Disease or injury Cause) (Disease or injury)										
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phys the	resulting in death) Last	Due to (or as e consequ	ence of):				,			
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Is, P.O. Boses that the death of gneed by the attence be deteched for us by Physician.	Part II. Other significant conditions of				en in Part I.		Yes 2 No	atribute to the cause of death? 3 □ Probably 4 □ Unknown			
S, P es that igned k be det	Left Femur Fract	ure with Comp	Lication	ns		_ ''	20110	SETTOMONY 4E STRAIGHT			
I Records, P.O. Bo The law requires that the death set has been signed by the atter page 2 should be deteched for the completed by Physicial							an autopsy ormed?	24b. Were autopsy findings available prior to			
The law requireste has been single has been single Completed						_	,,,,,,	completion of cause of death?			
The law te has bage 2:						10	Yos YINO	1 ☐ Yes 2 ☐ No			
	25. Was case referred to medical examiner?				26. Place of I	Death (Check only	one)				
Of Vita Physician: this certific ral director,	1X Yes 200	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Othe	er: Nursing	g Home 5□ Resi	dence 6 Othe	er (Specify)			
n og Pt ter ti nera	27. Menner of Death 11	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury Work	/ at k?		how injury occurr	red			
Vision Attending or death. ector: Attento by the fune	Accident investigation	04/19/2007	Unknowi	1 M	Yes 2 🛣 No	Subjec	t fell				
Division c bit or Attanding Property and Director: After the din by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, State) 73(or Rural Route Number, O Route 3 South			
C rai of S		Assisted Liv				Gambr.il	ls, MD				
Division To the Hospital or Attanding within 24 hours efter death. To the Funaral Director: After completely filled in by the fune Medical Certification	29a. Certifier Certifying Ph (Check only one)	ysician: To the best of my kno liner: On the basis of exemine	owledge, death o etion end/or inve	occurred at the time estigation, in my op	ne, date and pla pinion, death o	ace, and due to the ccurred at the time,	cause(s) and ma date and place, a	anner as stated. and due to the cause(s)			
Mex Mex	29b. Signature and title of certifier	end manner stated.		29c. License	number		29d. Date signed	d (Month, Dey, Year)			
F > F o	Rakosh	anona	MA		201	08	7/11	107			
	30. Name end address of person who							1 /			
	30. Name end address of person who RAICES IT AROR	A,M014300	GALLI	7N7/2	XLN	150 W1	E MD	20715			
State	31. Date filed (Month, Day, Year)	20 Dilitare de Cien	nturo								
Registrar	JUL 1 9 2	2007	1. An	week)							
DHMH 16 Rev 6/95											

		State Amend	#911,16a	State of :-19b, per	Marylan AB 6869,	d / Depa 7/20/07	rtment of H	lealth and I	Mental Hygien Reg. N	e - 2007	23201		
		Registrar 1. Decedent's Name (/				001	inoate or i		Reg. N	O. t U U /	3. Time of Death		
Physicia		Samuel Sw							JULY O	ay Year 1 2007	04:55 PM		
/Medic Examin		4a. Facility Name (If no			ber)		4b. Citv. Town, or	Location of Death		c. County of Death	01.351		
Examili	er	SINAI			BALTI	MARE	BALTIM	DEE CI	YY				
Funeral		5. Social Security Num			Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthr	place (State or Foreign		
Director		218-38-363	31	1 ∑ M 2□F	71	Yrs.	Months Days	Hours Min.	Aug 4, 193	5 Washir	ngton, DC unk		
D		Usual Residence of De		112010									
how lat	_	10a. State	0b. County	unk	10c. City	y, Town or Lo	cation				10d. Inside City Limits nk _{1 □Yes 2 □ No}		
e Ma Sa-f s tiffiec	5	MD									Yes 2 No		
or 28	Director	10e. Street and Number	er			unk	10f. Zip Code			itizen of What Cou	ntry?		
ath w			113012							USA			
er de	Funeral	11. Marital Status	unk	12. Was Deced	:es?		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,			
s afte	by F	1 X Never Married 3 Widowed 4 [1 ☐ Yes If Yes, Give Year or Da	9	1	☐ Yes 2∏ No	Specify:		Specify: wh	ite		
houn tural	ba		5. Decedent's			16a. Deced	ent's Usual Occup	ation	16b.	 Kind of Business/In	dustry unk		
in 72 n "na Aedio	Completed	(Specify Elementary/Seconds	only highest g	grade completed)	4== 5 . \	(Give	kind of work done o OO NOT use retired	during most of wor d)	king				
y with	E O	unk	ary (0-12)	College (1- unk	401 5+)	Sanitat	ion worker		Sani	tation coll	ector		
othe /ent,	Bec	17. Father's Name (Fin	rst, Middle, La	st)			unk	18. Mother's Nan	ne (First, Middle, Maide	en Surname)	unk		
uld be Aenta Aenta rked rked tic ev	10 E	Samuel E. Sv	wearinge	n, Sr.				Sally Drig	gers				
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		19a. Informant's Name	e/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Number, City Baltimore, N	or Town, State, Zip	Code)		
and 2 salth :		Sinai Hosp	oital	iieys orritoe		2401	W. Belve	dere Aver	ide Baltimo	re, MD 2	1215		
of He roth		20a. Method of Dispos		☐Removal from S	1 6	Place of Dispos emetery, cren	sition (Name of natory or other plac	ce)	Date 20c.	Location - City or To	own, State		
Pag nent ant: It		4 □ Donation 5	Mother (Spe	cify) in sta	te								
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune	ral Service Lic	Pleasa	nt .	22 S t	Name and Addre	ss of Facility	d 655 W. Ba	1+1	Charach		
825 8 8		with	myl) Lear	ant		ltimore,			tremore :	orreer		
200 18		23a. Part1. Enter the shock, or heart f	disease, or co	emplications that can be one cause on ea	used the deat ch line.	h. Do not ente	er the mode of dyin	ng, such as cardiad	or respiratory arrest,	!	Approximate Interval Between		
Physician		Immediate Cause (Findisease or condition	nal	ANG	KIC	ENCI	= PHALO	PATHY		11	Onset and Death		
/Medical		resulting in death)	- 4		r as a conseq		1111			-			
Examiner		Sequentially list condi	itions.	b									
D tis	Examiner	Sequentially list condi- cause. Enter Underlyi Cause (Disease or inju- that initiated events	ediate ring	Due to (c	ras a noming	tienna afti:							
ecute and -trans	Cam	that initiated events resulting in death) Las	ury st	C		uanaa af):							
be executed sician and burial-transit	<u>E</u>	,		Due to (or as a consequence of):									
cate o	dical			d									
ding se as	Me	IF FEMALE:		23c If yes out	ome of pream	ancv				ood Data of dalling			
leath certifi attending p	ian	23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day Ye			
at the de by the a	by Physician/Me	1 ☐ Yes 2 ☐ N 9 ☐ Unknown	No	9□Unkno									
res that igned by be deta	۳.	Part II. Other significa	ant conditions	s contributing to de	ath but not res	ulting in the ur	nderlying cause giv	23e. Did tobacco	use contribute to t	he cause of death?			
uires 1 sign 1d be	d b	HYPER	TENT	TION					1 ☐ Yes	2 No 3 Pro	bably 4 Unknown		
w require been sign	lete								24a. Was an	24b. Were auto	opsy findings available		
he lav e has	Completed								autopsy performed?	prior to co	impletion of cause of		
sictan: The certificate hi irector, page		25. Was case referred	dao medical					26 Place of Dec	1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	√o 1 ☐ Yes	2 N o		
/sicla	o Be	examiner?		Hospital:	patient 2	ER/Outpatien	t 3 DOA Oth	or	fome 5 ☐ Residence	6 Other (Speci	6/)		
a Phy erthis eral c	. To	27. Manner of Death		28a. Date o	f Injury	28b. Time of	28c, Injur	v at	28d. Describe how in		<i>y</i>		
nding th. :: Afte	ıţi	1. ☐ Natura! 2 ☐ Accident	5 Pending investigat	1 '	n, Day Year)	Injury	Mor M 1 □	k? Yes 2∐No					
Atter r dea ector by th	i‡i		6 Could not determine	ad 28e. Place			eet, factory, office		28f. Location (Street		al Route Number,		
al or s afte	Certification:	4 I Homicide		Dullaii	g, etc. (Specif	<i>y)</i>			City or Town, Sta	ne)			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1[(Check only 2]	Certifying	Physician: To the	best of my kno	wledge, death	occurred at the til	me, date and place	e, and due to the cause urred at the time, date a	(s) and manner as	stated.		
the H in 24 in 24 ihe Fi	Medical	one)		and mann	er stated.	and/Utiff							
With To t	Σ	29b. Signature and titl	le of certifier	Mahra	1 W.	D	29c. Licens			Date signed (Month,	Day, Year)		
		•	1,/chi	14 1000			RES	000) []	1/4 01,	2007		
		30. Name and address	-			n 23a) (Type,				C			
) (i)	MAN		TALWA		1	SINAL	HOS PI	TAL OF	BALTI	MORE		
Sta	- 4	31. Date filed (Month,		200	gistrar's Signa	ature A							
Registr		JL	JL 1 9	2007	Solas K	7. 60	all!	· · · · · · · · · · · · · · · · · · ·					
HMH 17 Rev 1/20	001			Re		4							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending

Baltimore, Maryland 21215-0036

To the Hospital or Attend within 24 hours after death To the Funeral Directors filled in by

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

29a. Certifier (Check only one)

and manner stated.

29c. License number P21178

(X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month Day Year) July

30. Nation and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jose C. Cabassa 22 S. Greene St., Baltimore, Md 21201

31. Date filed (Month, Day, Year) State

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Firme of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0200 M 7 2007 Justin tone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UMMC - Shock Baltimore Irau ma If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 30,1988 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours 1XM 2□F 18 MD 213-25-4523 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21061 U.S.A. 703 Old Stage Road Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed or than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 10 Construction 7 is marked other traumatic event, to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary A. Albrecht Charles L. Stone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health au Important: If item 27 is any injury or other trau Mrs. Mary A. Stone/Mother 703 Old Stage Road Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July Date 23. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Elkridge, MD Meadowridge Memorial 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Singleton Funeral for 21. Signature of Funeral Service Licensee Moi357 1 Second Avenue SW Glen Burnie, MD 2/V23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac spiratory are shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): EXAMINER BERTIFICATION APPROVED BY MEDICAL Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties of the second 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 ⊠No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Dyatural 5 Pending investigation 46 7011 5: 1 ☐ Yes 2 ☑ No struck Vehicle 2 Accident I Director: d in by the 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 ☐ Homicide

Registrar DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral I

Medical

State

29a. Certifier

29b. Signature and title of

31. Date filed (Month, Day, Year)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

18321

29d. Date signed (Month, Day, Year)

Baltomore

2007

Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rollstin

and manner stated.

South

32. Registrar's Signature

7-05452		Please Ty	pe or Print i	n Black I	ndeli	ble Ink	. Ensur	e All C	Copies	Are L	egible	e.		
Orville Edward S		0.0	tate of Maryl					ıd Men	ıtal Hy	giene		9	77	7 232
		1- For State Registrar		C	ertifica	ate of D	eath				Reg. No.		UU	
Physicia		Decedent's Name (First, Midd	·						2	2. Date of Do Month	Day	Year		3. Time of Death
Medical Exami	ner	Orville	Edw			Scor				July 16,	2007			0745 hrs
		4a. Facility Name (if not institution 385 Phirne Road West	-	umber)			City, Town, o Glen Burni		of Death			c. County o Anne Aru		
Europal		5. Social Security Number	6. Sex	7. Age (In yrs.	last hirth		f Under 1 Yea		er 24Hrs.	8 Date of				nplace (State or
Funeral Director						7	Months Day				·	· ·	Foreign	1
J0010.		396-38-1304	1 X M 2 F	8	5	Yrs.				May :	30,19	922	Cou	ntry) WI
gt		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town	or Location				•				10d. Inside City Limits
		MD Anne	Arunde1	C1 o	n D.,	wn i o								1 Yes 2 X No
daryland 28a-f show 1 at once.	휭	10e. Street and Number	Arunder	GTE	n Bu		Of. Zip Code				10a. Cit	izen of Wh	at Coun	trv?
ith the Maryland 23a or 28a-f sho notified at once.	Director	385 Phirne Roa	ad West					061		- 1		S.A.		
with the s 23a		11. Marital Status		cedent Ever in	U.S.	13. Was D	ecedent of Hi		gin? (Spe	cify Yes or I			- Americ	an Indian, Black,
eath v	Funeral	1 Never Married 2 X M					specify Cuba					White		
fter d		3 Widowed 4 Div	vorced If Yes, Give Yes	6/12-1965		í Ye	s 2 X No	specify:				Specify:	Whi	te
ours;	d b	15. Decedent's Education (Spe			16a. E	ecedent's l	Usual Occupa	tion (Give	kind of wo	ork done	16b.	Kind of Bus	iness/In	ndustry
6 72 h	Completed	Elementary/Secondary (0-12)		1-4 or 5+)			of working life							
vithin ene.	립		2		Ma	ster	Sergea	nt -U	JS Arı	ny	Ţ	JS Arı	ny	_
15-00 Ted wit Hygien d other		17. Father's Name (First, Middle	e, Last)					18.Mother	r's Name (First, Middle	e, Maider	Surname)		
21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	Be	Emil Score	1: (T		140				tie]					
ari is	P	19a. Informant's Name/Relations Mrs. Gerda Scot					dress (Stre							
more, ME Pages I and 2 s nent of Health an ant: If item 27		20a. Method of Disposition	re /wire	20b			irne R			Date 1				Town, State
2 - S - S - S - S - S - S - S - S - S -		1 Bunal 2 X Cremation	n 3 Removalf	rom State	cremato	ry or other	place)		Ju1	y 17,				
ti. Partiment timen	ļ	4 Donation 5 Other S		Cl	nesar		Cremat			007				le, MD
Baltimo permit. Page Department c Important: injury or oth		21. Signature of Funeral Service	Licensee	214044			e and Addres		. DTI	gleto	n Fu	neral	Hor	me, P.A.
Physician	-+	23a. Part I. Enter the disease, or	r complications that	MO14										LUDI Approximate Interva
/Medical	18	failure. List only one cause	e on each line.				, ,			. ,			E 24	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		a consequence					_				_	
		Sequentially list conditions,	b											
	Ē	if any, leading to immediate		a consequence	of):									
,	Examine	(Disease or injury that initiated events resulting in death) Last	C	a consequence	of):									
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760, ficate be exe g physician a	ĕ	IF FEMALE:	23c. If yes,	outcome of pre		0/0/ 11					23	d. Date of	delivery	
687 ertific	ian/	23b. Was decedent pregnant in the past 12 months?	Live		2	Fetal	death 3	Ectopie	c pregnan	су	ļ	Month	Da	ay Year
Box 68760 death certificate be the attending physical for use as the bu	Physician/Medio	1 Yes 2 No 9 Uni	7	nant at time of o	seath 5	Other	(Specify)				1			
P.O. B that the de	듄	Part II. Other significant condit		to death but not	resulting	in the unde	erlying cause	given in Pa	art I.	23e. Dic	tobacco	use contrit	oute to the	he cause of death?
, P.O. res that the signed by be detacl	þ						, ,			1 🔲 Y	res 2	/ No 3	Proba	ably 4 Unknown
ords, w require	Completed									24a. Wa	as an	24b. W	ere aut	opsy findings available
COT law r has b	휌										topsy formed?		rior to co eath?	ompletion of cause of
tal Recion: The certificate rector, page	3								Y	1 Yes	s 2 N	No 1	✓ Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	å	25. Was case referred to medica examiner?	(Hospital:			·		of Death Other					0.011	0
Physic Physic er this	2	1 ✓ Yes 2 No 27. Manner of Death		Inpatient 2		tpatient 3 ime of Injur		Jry at Work		Home 5		ence 6 V		Scene
nding Phy Ith. :: After tl	<u>.</u>	1 Natural 5 Pend	- (Ment	h, Day,Year)	FOU	ND:		Yes 2	- Is	ubject fe		jury occurre		
ivisior or Attencather death Director:	<u>ä</u>	2 Accident Inves	stigation Jul 16,	2007 ce of Injury - At	0730					8f Location	(Street	and Numbe	er or Rur	al Route Number, City
Div tal or al Dir	Certification:	dete	la not be	Single Fa						or Town 85 Phirne				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring.	- 1	4 Homicide 29a. Certifier 1 Certifying P	hysician: To the be			th occurred	at the time. d	ate and nls		-				
thin 2 the I	Medical		miner: On the basis	of examination										
To You	Se l	29b. Signature and title of certific	er and manner:	states. /			29c. Licens	se number			29d.	Date signe	d (Mon	th, Day, Year)
		XII//N	///	V			O.C.	M.E.			July	y 17, 200)7	
10	ŀ	30. Name and address of person	who completed cau	se of death (Ite	m 23a)									
V			Assistant Madi		,	1 Done 9	Stroot Pol	timore !	MD 242	01				

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 2^{Day} 1. Decedent's Name (First, Middle, Last) Physician 115 PM HIRLEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GLEN ALTIMIZE WASHINGTON NIEDICAL ENTER ARUNDEL 8. Date of Birth (Month, Day, Year) Nov. 24,1941 Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🕅 F 65 MD 212-42-8873 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, <u>the Medical Examiner must be notified</u> at 1 ☐ Yes 21 No Director Anne Arundel Glen Burnie MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 201 McGuirk Drive 21060 Funeral 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 🛣 No Specify Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) U.S.Government Keypunch Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Lou Winge Steve Jawanawhich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 201 McGuirk Drive Glen Burnie, MD 21060 Mr. Joseph J. Sarro/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July Date 16, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Glen Haven Mem. Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility Singleton Funeral Home, Mo/357 1 Second Avenue SW Glen Burnie, MD 21061 January 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 Ø No 9 ☐ Unknown ρ Day 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2**X** No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2K No certificate Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA ဥ After this 28a, Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A Accident 🖒 🖒 completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State

Registrar

31. Date filed (Month, Day, Year)

30 \ 32. Registrar's Signature

Day, Year) 32. Registrar's Signatu

30. Name and address of peran who completed cause of death (Item 23a) (Type, Print)

forlis

ORIGINAL

and 2121

Baltimore, Mary

Box 68760,

P.0.

Division or Vital Records,

State of Maryland / Department of Health and Mental Hygiene 000 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 17, 2007 Physician 5:35 ам Emily Tykala /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Gilchrist Center Towson 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Min DEC" 1913 Il Thois 1 ☐ M 2 👿 F 93 336-56-8033 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21204 615 Chestnut Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If item 27 Is marked other the any injury or other traumatic event, the Jonce. Church Religious Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dominick Nellie Michael Tykala 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Chestnut Ave., Towson, MD Pickersgill, Inc.-Caretaker 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/20/07 Gardens of Faith Overlea, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dous /Medical Due to or as a consequence of): Examiner mirmion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy performe certificate 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) WSVI 4 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes P this 28a. Date of Injury 27. Manner of Death 1 D Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: (Month, Day Year) Hospital or Attending 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hazles St Powson no znoup AARON J CHANES MO 6701 N A. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2007

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

O. Box 68760,

Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State Registrar	State	e of N	/larylan				ealth a Death		ental Hy	giene Reg. No.	200	7	232	213
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* 6	Examin	er	4a. Facility Name (If not institution	-						Location of	of Death	4c. County of D					
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	how		10a. State 10b. County			10c. Cit	y, Town or Lo	ocation							100	d. Inside Cit	
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Baltimore,	permit. Pages Department of the Important: If Its any injury or of once		21. Sign ture of inneral Service	License			, 2: T	2. Name a	nd Addres	s of Facilit	al Ho	ome, In	С.				
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	4		30. Name and address of person	NALI	Mi	730	n 23a) (Type,	Print)	rer	PKV	vy C	Freenb	clti	MD Z	コチ	70	
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1 .	Registr	ar	OOL T	F001		ALL A	- Jay	- Har									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 27 AM Wayne Taylor 7005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) If Under 4 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 □ F 250-04-9713 13, Director 1955 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Y⊟Yes 2□No MD Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 727 Druid Park Lake Drive #13B 21217 **USA** Funeral 14, Race - American Indian, 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 827 Linden Avenue Baltimore, MD 21201 Maryland General Hospital 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licens
Antichony D. 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 Leasant 655 W. Baltimore Street 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has t autopsy performe certificate Nyocar 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 3 Suicide 5 Pending investigation 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

JUL 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician 9:40 PM Ruth Thompson 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hanes Health Care Baltimore n/a If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2**S**F Hours Yrs. 72 Director 9/30/34 231-36-4944 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 □ No Director Md n/a <u>Baltimore</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 608 Wildwood Parkway 21229 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ilth and Mental Hygier 27 is marked other the traumatic event, the 6 0 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Dennis unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health 16 Walden Laurel Court Baltimore, Maryland 21207 Mr. Ronnie Thompson / Son or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State artment of Loudon Park Cemetery: 7/20/07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Departr Departr Imports any nju 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licen 3620 Wilkens Ave. Baltimore, Maryland 21229 cec. 23a. Part1. Enter the disease, or conshock, or heart failure. List of plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONITIS ASPIRATION ONE HOUR /Medical Due to (or as a consequence of): Examiner FAILURE THE YEAR RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit 10 DAYS METASTATIC MALIGNANCY Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform rmed? 2**X** No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient Certification: To 3 DOA 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death the 3 Suicide 6 ☐ Could not be within 24 hours after de To the Funeral Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Jyothi Punnam, MD P19925 JUL 11, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. CATON BALTIMORE - 21229 JYOTHI PUNNAM, AVE 52. Registrar's Signature 31. Date filed (Month, Day, Year) State 2000 Registrar

homoson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State State Registrar	ite of Maryla		artment of H rtificate of I			iene _{eg. No.} 2	007	23216	
P			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	Year	3. Time of Death	
	Physicia /Medic		Ruth Elizabeth Taylor					July	7	2007 ^{Year}	1:35 PM	
4	Examin	er	4a. Facility Name (If not institution, give street a	ınd number)			Location of Death		4c. County of Death			
1.000	Funeral		2703 White Avenue 5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	Baltimore If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign	
	Funeral Director		216-28 - 7911	[™] 94	Yrs.	Months Days	Hours Min.	6/18/191	3	Mary 1	and	
	pug 💉	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation					10d. Inside City Limits	
	Maryla f sho	ro	Maryland N/A		ltimore						1 X Yes 2 □ No	
	r 28a-	irec	10e. Street and Number		. TOTALO	10f. Zip Code		1	0g. Citizen o	of What Cou	ntry?	
	th with	al D	2703 White Avenue			21214				JSA		
	er dea	Funeral Director	11. Marital Status 12. Wa	as Decedent Ever in med Forces? Yes 2 No	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		lace - Americ Black, White,		
36	irs afte	by F	If \	Yes 2 (No Yes, Give ar or Dates:		1 ☐ Yes 2 💢 No	Specify:		Spe	cify: Whi	ite	
215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's Education (Specify only highest grade comp	nleted)	16a. Dece	eedent's Usual Occupation we kind of work done during most of worki . DO NOT use retired)		ina	16b. Kind of	Business/In	ndustry	
7	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+)	I		i)	,,,,	Own H	-lomo		
12	iled w Hygiel ther th	S	17. Father's Name (First, Middle, Last)		Homema	iker	18. Mother's Name	e (First, Middle, I				
aŭ	ould be f Mental I arked of atic eve	To Be	Herman Meiser				Gertrude Ho					
Maryland	s 1 and 2 should be of Health and Menta Item 27 Is marked other tranmatic events.		19a. Informant's Name/Relationship (Type. Pr	al Route Number	*		p Code)					
	1 and 2 Health em 27 I		Ronald J. Taylor / Son	Toos		reenbank Ro	,	nore, Mar	<u> </u>	21220 on - City or T	04-4-	
altimore,	Pages 1 nent of H int: If Iter iny or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove	al faces Charles	cemetery, cre	osition (Name of matory or other place Vat'1 Cemete	ce) ;	2007				
<u>=</u>	permit. Pages Department of Important: If It any Injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Signa	1 1		2. Name and Addre		305 Harfor		e, Mary	/land	
ñ	Dep lmp		Michael & Revo	b Xr	Le	eonard J. Ri				nd 21214	4	
Ü			23a. Part1. Enter the disease, or complication shock, or heart failure. Est only one cau	s that caused the de se on each line.	eath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Alzheim		le ment	10				2 years	
	/Medical Examiner		Todaning in deality	Due t (or as a cons	equence of):						1	
0	18 M	Jer	Sequentially list conditions, if any leading to immediate	Due to [or as a cons	e uence of):							
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			- Marie - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -						
60,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):							
58760,	ficate I physics the b	edical	d									
ŏ	leath certifi attending I for use as	n/Me		yes, outcome pf preg		⊒Ectopic pregnanc			23d.	23d. Date of delivery		
Box.	e death	Physician/M	1 Ves 2 No	□Live birth 2 □ Fo □Pregnant at time o □Unknown		Other (specify)	y 			Month	Day Year	
о. О	hat the d by the letach	Phy	9 ☐ Unknowh\ Part II. Other significant conditions contribut		resulting in the u	ınderlying cause giy	en in Part I	23e. Did to	hacco use c	ontribute to	the cause of death?	
Records,	w requires that the de been signed by the s should be detached i	d by	, a.v., a.v.	···g	,			1 □ Y	es 2 N	o 3 Pro	obably 4 □Unknown	
Ö	w req	lete		-				24a. Was a		b. Were aut	opsy findings available	
Re	Physician: The law r this certificate has ral director, page 2 a	Completed						autop: perfor 1□ Yes	sy med? 2 X No	prior to co death? 1 ☐ Yes	ompletion of cause of 2□ No	
<u>ta</u>	ctor, p	Be C	25. Was case referred to medical examiner?			T-	26. Place of Deat		/\			
2	Physic this or	유	1 ☐ Yes 2 No	al: 1 ☐ Inpatient 2 a. Date of Injury	ER/Outpatie		4 L Nursing Ho	ome 5 Resid			ify)	
O	iding Phi h. : After thi funeral	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year,		Wor	rk? Yes 2 □ No	zou. Describe II	ow injury oo	ounca		
Division or Vital	or Attendater death Director: in by the	Certification:	OFF	e. Place of injury - Af building, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (S City or Tow		ımber or Rui	ral Route Number,	
ā	Ital or its after ral Dir	Cert										
	Hospital	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: 0									
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Mec	29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date sig	gned (Month	, Day, Year)	
	->-0		Dam way Rosent	W MD	e m	D3	31025		JULY	17,2	007	
•	1		30. Name and address of person who complet	ed cause of death (I	item 23a) (Type	, Print)	٧٠٧ ٢	101	2 1000	10.1.	danie	
	4		Only wolf Rosentho	32 Registrar's Si	gnature 4	STRANIS	11201 6	WIIME	ح ۱۷۱۵	redian	d 21218	
	Sta Regista		JUL 1 9 200/	Jan Burn	13. 190							

07-05236

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Villiam Upshaw	State of Maryland / Department of Health and M Certificate of Death		g. No. 2007 222!
Physician/	1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
Medical Examiner	WIIIIam	July 7, 200	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca Laurel Regional Hospital Laurel		Prince George's
Funeral Director	416-66-3208 1XM 2F 62 Yrs. Months Days H	Under 24Hrs. 8. Date of Birth Hours Min. June 13	n(MW/DD/YYYY) 9. Birthplace (State or Foreign CountryAlabama
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show I at once, ector	Maryland Prince George's Laurel		g, Citizen of What Country?
th the Maryland 23a or 28a-f sho notified at once.	7613 Carissa Lane 20707		U.S.A.
r death with or items 23 must be no Funeral	1 X Never Married 2 Married Armed Forces S S If Yes, specify Cuban, Me		14. Race - American Indian, Black, White, etc.
urs after	3 Widowed 4 Divorced If Yes, 1901 Play a ilable 1 Yes 2 1 No sp	Give kind of work done	Specify: Black 16b. Kind of Business/Industry
5-0036 ed within 72 hour 1/9 ygiene. other than "natu the Medical Exaut Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ International Rel		r Federal Government
5-0036 led within 7/ Hygiene. other than the Medical		other's Name (First, Middle, M	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Comple	, .	Jeary L. Johns	
e, MD 2121 t and 2 should be f Health and Mental item 27 is markee r fraumatic event,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and		ber, City or Town, State, Zip Code)
e, MD 2 and 2 shou Health and N item 27 is r traumatic	Geraldine Locke (Sister) 835 Brandy Circ. 20a. Method of Disposition 20b. Place of Disposition (Name of cemete		1, AL 35214 20c. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: G.W. Carver Cemeter		Birmingham, AL
Salti ermit. Pepartn mport. njury o	21 Signature of Europea Copying Alicana a	acility eral Services	ngham, AL 35208
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	er Rd., Birmir n as cardiac or respiratory arre	ngham, AL 35208 est, shock, or heart Approximate Interval
/Medical raminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease)		Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
uted daransit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.		
SO, te be executed ysician and burial - transit	UNPENDED AMENDED		
ox 6876 auth certifical attending ph or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Ectopic pregnancy	23d. Date of delivery Month Day Year
s, P.O. Baires that the de signed by the detached for be detached for by Phy			bacco use contribute to the cause of death? 2 No 3 ✓ Probably 4 Unknown
IS, P quires t an sign lid be c	Liver cirrhosis, diabetes mellitus	24a. Was a	
Vital Records, P.(sician: The law requires tha his certificate has been signed director, page 2 should be det O Be Completed by		autop:	sy prior to completion of cause of death?
tal Rection: The certificate ector, page	25. Was case referred to medical 26.Place of I	1 ✓ Yes : Death (Check only one)	2 No 1 Yes 2 No
/ital sician sician lis certi	examiner? Hospital: 4 Innations 2 of EP/Outpatient 3 DOA Oth		Residence 6 Other:
Division of Vital Records, P.O pital or Attending Physician: The law requires that tours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detacted by Free Certification: To Be Completed by Free Completed by F	1 Ves 2 No 1 Imparent 2 Vertootopation 3 Don't Imparent 3		now injury occurred
Division o spiral or Attending rours after death. Tilled in by the fune fulled in by the fune Gertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building (Specify)	ing, etc. 28f. Location (S or Town, S	Street and Number or Rural Route Number, City tate)
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Check only Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and due to the caus	e(s) and manner as stated.
To the 11c within 24 To the Fu To the Fu complete!	29b. Signature and title of certifier 29c. License nu		29d. Date signed (Month, Day, Year)
	Paliett O.C.M.E		July 9, 2007
5	30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201	
State			
Registral	ORIGINAL	COME	

VANSANT KATHERINE F
Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26 per VERB G869 7/19/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician July 1145 AM 18 F. Van Sant Katherine 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AA COUNTY BALTIMORE WASHINGTON HEDICAL CENTER GIEN BURNIC If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, June 04 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours 1 ☐ M 2 🖾 F Months MD 216-01-9537 90 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Glen Burnie Anne Arundel Maryland 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 USA 203 Oak Lane, N.W. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☑ No Specify. Specify: ģ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK Frederick UNK ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry K. Core Jr. (nephew) 3901 Brookstone Drive, Winterville, NC 28590 July Date 19 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linesee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the visease, or complication, trait aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SYSTOLIC HENRY FAILURE HRONIC Physician /Medical Due to (or as a consequence of): HELET Examiner HYPERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HYPERTENSION burial-transit Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate l 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 35621 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRENS 0 DAVID. 31. Date filed (Month, Day, Year)

JUL 1 9 2007 32 gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day July 18, 2ď07 Marie Elizabeth Volandt 1:50AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Genesis Elder Care Severna Park Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 X F 89 Yrs. June 5, 1918 MD 213-18-7034 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No MD Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 565 Knollwood Road 21146 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Tarun Amelia Hepfeldt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Janie A. Beitle /Daughter 189 Magothy Beach Road Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) July 21, 2007 Glen Haven Mem. Park Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1 Second Avenue SW Glen Burnie, MD 21061 anu 01357 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lile 1011 J Wh Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 -No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes ≱ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 TNo

Examiner death certificate be executed and physician s the burial Box 68760, attending ph for use as t signed by the a d be detached f P.0. Division or Vital Records, page 2 should neec Jas certificate

this

After I or Attending I after death.

To the Hospital within 24 hours a To the Funeral C

filled in by

Medical

Physician

Examiner

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at

Department of Health and Mental Hy, Important: If Item 27 is marked other any Injury or other any Injury or other the second any Injury or other the second
Physician

/Medical

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

9

Completed

Be

Examiner Physician/Medical þ Completed funeral director Be 2 Certification: Director: /

27. Manner of Death

1 Natural

2 Accident 3☐ Sulcide

4 Homicide

31. Date filed (Month, Day

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

5 ☐ Pending investigation 1 🗌 Yes 2 🗆 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and the of dertifier

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

108

32. Registrar's Signature

DI Douch

State

Registrar

Maurice G. White, Jr.

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6	1	100	2	-	1	leven	line	1

torice G. Write	1-	- For State Certificate of Death Reg. No.				
Physicia edical Examir	n/	Registrar 1. Decedent's Name (First, Middle,Last) MAURICE G. WHITE, JR. 2. Date of Death Month Day Year July 15, 2007 2.40 hrs				
edioa: Zxaiiii		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 5700 Radacke Avenue 4c. County of Death Baltimore City				
Funeral Director		5. Social Security Number 219-25-6918 6. Sex 7. Age (In yrs. last birthday) 22 yrs. If Under 1 Year If Under 24Hrs. If Under 2				
Aaryland 28a-f show any: 1 at once		Usual Residence of Decedent 10a. State	_ 1			
the Maryl a or 28a-1 tified at o	Director	3400 CHESTERFIELD AVENUE 21213 USA				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Merial Hygene 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Local Occupation (Give kind of work done) 16b. Kind of Business/Industry				
5-0036 led within 72 hour Hygiene other than "natu	ompleted	Elementary/Secondary (0-12) 11 College (1-4 or 5+) SCREEN PRINTER PRINTER PRINTER				
21215-0036 suld be filed within 7 Mental Hygiene marked other than	3e C	MAURICE G. WHITE, SR. LORETTA CARPENTER				
nore, MD 2121 ages I and 2 should be fi nt of Health and Mental t: If item 27 is marked other traumatic event,	To	LORETTA CARPENTER / MOTHER 3400 CHESTERFIELD AVE, BALTIMORE, 2121	3			
- 6 d = L		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ARBUTUS MEM. PARK 7/20/07 BALTIMORE CO.,	MD			
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	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unserlying Cause (Disease or injury that initiated within it death) Lead				
ecuted and and transit	al Exa					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and nane? should be detached for use as the burnal - transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Ye.	ar			
O. BC hat the deset by the set by the set by the set by the set between for the set by the set between for the set by the set between for the set by the s	by Phy					
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. After this certificate has been signed by the attending professional defined in the state for the property and a function made?	ompleted t	24a. Was an autopsy findings a prior to completion of call performed?	vailable use of No			
l Re n: The tificate	CO	25. Was case referred to medical 26. Place of Death (Check only one)				
Vita sysician this cer	B O	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outpatient 3 Doa Outpatient 4 Nursing Home 5 Residence 6 Outlet Scene				
on of anding Pt ath.	tion: T	1.27 Manner of Death 1288, Date of Illuly 1288, Talle of Illuly	- City			
Division tall or Atternation and Director in the Contractor in the	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Numbor or Town, State) 5700 Radacke Avenue, Baltimore City, Md.	er, Gity			
the Hospi iin 24 hou the Funer	Medical Co					
To the within Z To the	Me	and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) July 16, 2007				
6		30. N and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
	Stat	te 31. Date filed (Month, Day, Year) 2007 32 Registrar's Signature				
Reg	istra					

Patr	rice Willis	1	State (ent of Health and Mental H ate of Death	ygiene	200	7 2322
	Physicia	F	Registrar 1. Decedent's Name (First, Middle,Last		ale of Dealif	Reg. 2. Date of Death		3. Time of Death
Me	dical Examir		PATRICE	,	WILLIS	Month D July 16, 200	ay Year 7	1707 hrs
			4a. Facility Name (if not institution, give	e street and number)	4b. City, Town, or Location of Deat		4c. County of Death	1/1
		Ц	Bon Secours Hospital		Baltimore thday) If Under 1 Year If Under 24Hr	Date of Birth	MM/DD/YYYY) 9. Birth	unlace (State or
	Funeral Director	-	5. Social Security Number 6. Se	6.07	Months Days Hours Min	— `	Foreign	
	Director	k	Usual Residence of Decedent	M 2XF 37	Yrs.	MAKCH I	1,19 10 00	TARYLAND
	any	ŀ	10a. State 10b. County	10c. City, Town	or Location		\sim	10d. Inside City Limits
	*	۱	MARYLAND N/	A	BALTIMO	PRE (ITY	1 X Yes 2 No
5	faryla 28a-f	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	try?
	3a or	히	2314 WING	HESTER ST. API	T.L 2121	6	USA	
	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Americ White, etc.	an Indian, Black,
	er deal	필		1 Yes 2 No	1 Yes 2 X No specify:		Specify: P1	ANV
	irs afte	à	Wildowed 4 Divorced Divorced Specify or	Lor Dates:	Decedent's Usual Occupation (Give kind of		6b. Kind of Business/Ir	ndustry
	72 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DO NOT use re	tired)	-0	
	036 rithin ene. or than	Id III	12 HAGRADE	5	BEAUTICIAN		SEAUTY	SALON
	21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, Middle, Last)	∤ Willis →//	18.Mother's Nam	e (First, Middle, Ma	iden Surname)	A A A
	121 Id be f fental narke	Be	19a. Informant's Name/Relationship (T	I VV	bb. Mailing Address (Street and Number of	Rural Route Number	er. City or Town, State.	Zip Code)
	Baltimore, MD 21215-C permit Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the	٩	JUSTILE TIS	TAC (MOTHER)	2314 WINCHESTE	RIST AF	T. L BALTO	D. MD 21216
/	ore, MD s 1 and 2 sho of Health and If item 27 is ner traumati		20a. Method of Disposition	20b. Place	of Disposition (Name of cemetery,		20c. Location - City or Woodlawn	Town, State
	Baltimore, permit Pages I an Department of He Important: If ite		1 X Burial 2 Cremation 3	A dimen	Memorial Park	-21-57.	ANSTON	MA MA
1	Baltimo permit Page Department of Important: injury or oth	1	Donation 5 Other Specify: Signature of Funeral Service Licen		22. Name and Address of Fa Ility	2001124	TR. FUN	DA OME
	Lift Per W		which N.	Williams	2145N. FULTO	NAVE.	BALTO M	10.21217
	Physician	\neg	23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the death. Do nach line.	not enter the mode of dying, such as cardiac	or respiratory arrea	, shock, or heart	Approximate Interval Between Onset and
	/Medical	1	Immediate Cause (Final disease a.	Methadone intoxication	on	·		Death
	,		or condition resulting in death)	Due to (or as a consequence of):				
		ē		Due to (or as a consequence of):				
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/	ited d ansit	Exa	events resulting in death) Last	Due to (or as a consequence of):				
	o, e be executed ysician and burial - transit	edical	XUNPENDED	AMENDED 17, 20b, #23a,PII,27,28a-f	0 000	07 vt		
	60, ate be	Med	IF FEMALE:	23c. If yes, outcome of pregnancy	<u>, perME,C871, 9/26/07 TT</u>		23d. Date of delivery	,
	6876(certificate nding physise as the b	jan/	23b. Was decedent pregnant in the past 12 months?	Description of dooth	2 Fetal death 3 Ectopic preg	nancy	Month E	Day Year
	Box 6876 re death certificate the attending phy led for use as the	Physician/M	1 Yes 2 No 9 Unknown	·	5 Other (Specify)			
	that the death certificate the by the attending phydetached for use as the library.		Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause given in Part I.		acco use contribute to	
	P. Cres that signed be det	d b	Hypertensive ath	erosclerotic cardiova	ascular disease	1 Yes	2 No 3 Prot	pably 4 V Unknown
	rds requi	lete				24a. Was ar autops		topsy findings available completion of cause of
	eco re law te has	Completed by				perform	ned? death?	
	Division of Vital Records, P.O. Box within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternompletely filled in by the funeral director, page 2 should be detached for up		25. Was case referred to medical		26.Place of Death (Chec	k only one)		
	Vita nysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 V ER/0	Outpatient 3 DOA Other Nur	sing Home 5 R	tesidence 6 Other	:
	ing Pl After Unnera	L:ú	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	. Time of Injury 28c. Injury at Work?		ow injury occurred	
	tend death.	atio	1. Natural 5 Pending 2 Accident Investigat		nd 4:16 pm 1 Yes 2 X No	unk		The state of the s
	ivis lor A after o Direct	tific	3 Suicide 6 X Could not determine	be	farm, street, factory, office building, etc.	28f. Location (St	reet and Number or Ru	ral Route Number, City MD ot L Baltimore
	D spita hours ineral y fille	Ce	4 Homicide	Tourid at				
	the Ho in 24 the Fu	Medical Certification:	Chack sale Certifying Filysic	ian: To the best of my knowledge, d r:On the basis of examination and/or	eath occurred at the time, date and place, a rinvestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stat nd place, and due to th	e cause(s)
	To To con	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Mo	
		9	Dona nu	Dinantimo	O.C.M.E.		July 17, 2007	
	V. Der	of E	30. Name and address of person who					
	1000		Donna M. Vincenti, MD	Assistant Medical Examine		MD 21201		
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 0			
	Regis	trar		2007 June 15	parti ?			
	DHMH 17 Rev 1/2	001	00	OME O	RIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 24a per verb., g869/607/19/07/14 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2007 1:50P M1. Gerald E. Wade JULY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Boonsboro Reeders Memorial Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar 5, 1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F "Mb Yrs. 86 214-16-0856 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Boonsboro Funeral Director MD Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 141 South Main Street 21713 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: *43-45 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify. Specify: white ģ 3 ☐ Widowed 4 🌣 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Worker Transportation unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Marie Forrest Elmer Luther Wade, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeri Roberts/granddaughter 3926 Trego Mountain Rd. Keedysville, MD 21756 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ADonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Anthony 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Pleasant 655 W. Baltimore Street Tousa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** meumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examine spital or Attending Physician: The law requires that the death certificate be executed ours after death.

In a fear this certificate has been signed by the attending physician and filled in by the funeral director. Due to (or as a consequence Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4⊡Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Degenerative AThrits 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2€ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O.

State Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and



and manner stated.

makes

29c. License number

D 44996

29d. Date signed (Month, Day, Year)

301-432-8470

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year MA P580 **Physician** WALKER ELEN 2007 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number **Examiner** Hospiral CIEV BALTIMORE HOPKINS 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday). Social Security Number **Funeral** 219.18.9812 1 ☐ M 2 🔀 Mb Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ns 23a or 28a-f shov must be notified at Baltimore 1XYes 2 No MD Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n 21205 N. Kenwood Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Nursing Assistant 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Inomas KObert ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship, (Type. Print) Illie Boyd 1041 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD 07/21/07 Mbutus Memonal Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jung 1 C. Greene Pullary Sonice Barton tre MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athrosdorotic Coronary DISEASE **Physician** YEARS /Medical Due to (or as a consequence of): Examiner HYPERTENSI Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No
9 Unknowh 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform No No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes No After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? Natural

Accident 5 Pending investigation 1 ☐ Yes ours after death.

leral Director: A
filled in by the fu 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 -LANG MO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mont

Registrar's Signature

3. Time of Death

9:00a M

Day 2007

July

17

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Margaret M. Wilfer

Funeral Director

Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at Show Director MD N/A Baltimore 10e Street and Number 10f. Zin Code d 2 should be filed within 72 hours after death with th and Mental Hygiene. ?7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be I 501 S. Glover Street 21224 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operator 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should Andrew Carl Wilfer Martha Lang 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any injury or other trau Andrew Booz – Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any to be to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Rly burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? . After Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier D 24276 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simon V. Scalia, M.D. 2801 Hudson St. Baltimore, MD 21224

32. Registrar's Signature

4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 501 S. Glover
5. Social Security Number Street Baltimore N/A 8. Date of Birth
9-2-1914 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🙀 F Maryland 92 217-12-5410 10d. Inside City Limits 1√Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 S. Glover St. Baltimore, MD 21224 20c. Location - City or Town, State Holy Redeemer Cem. 7-21-07 | Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed? Yes 2 No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🙎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) July 18, 2007

State Registrar 31. Date filed (Month, Day, Year)

	4	_ State Cer			
		Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	2. Date of Deat	
Physicia				Month	Day Year 1808
/Medic		Kathleen zaura 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	10017	4c. County of Death
Examin		Johns Hapkins Bayview Medical cente	r Baltimo	re	N/A
Funeral Director		5. Social Security Number 218-52-1915 1	if Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Year) Country)
		Usual Residence of Decedent 10c. City, Town or Lo 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Lir
shov dat	_			Desm	ıdalk 1 □Yes 2 🛭
8a-f	Directo	Maryland Baltimore	10f. Zip Code		0q. Citizen of What Country?
be n	늅	10e. Street and Number	21224		United States
s 23a	era	1011 Dalton Avenue 11 Modfal Status 12. Was Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Slif Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
permit. Pages 1 and 2 should be lifed within 72 hours after usean with the manyana. Department of Health and Mential Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 DNaver Married 2 TVMarried 1 DVes 2 T No	If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 No Specify:	o Rican, etc.)	Black, White, etc. Specify: White
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Hygir ther nt, th	ပ္သို	12 Years 17. Father's Name (First, Middle, Last)		ne (First, Middle,	Maiden Surname)
ed o	Be	Carville Hollingsworh, Sr.	Anna	Webb	
d Me matic	은	19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	ing Address (Street and Number or Ru	ıral Route Numbe	r, City or Town, State, Zip Code)
h an		Toda International Control of Con			, Maryland 21224
Healt Healt Healt Her ther			osition (Name of ematory or other place)	Date	20c. Location - City or Town, State
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07-05307 Robert Barbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Year Month Day July 10, 2007 1545 hrs Medical Examiner Jefferson Barbe Robert 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Allegany Cumberland Route 220 North If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Baden, PA Months Days Hours Min Director 1 **X** M 2 F Oct. 31,1941 235-60-3183 65 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f show notified at once. 1 X Yes 2 No MD Westernport death with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 421 Hammond Street 21562 USA 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 14. Race - American Indian, Black, 11. Mantal Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? Never Married 2 X Married 1 X Yes 2 b Divorced Yes, Give Year Vietnam War Yes 2 X No specify: Specify: White hours after <u>ک</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Trucking and Elementary/Secondary (0-12) permit Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Baltimore, MD 21215-0036 Courier Industries Self Employed Commercial Driver 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles J. Barbe Arlena E. Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt: If item 27 is m Viola V. Barbe/ Wife 12804 Marsteller Drive Nokesville, VA 20181 20b. Place of Disposition (Name of cemetery, 20c, Location - City or Town, State 20a, Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation July 15 2007 Hartmansville Cemetery Hartmansville, WV Other Specify: Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licens Smith Funeral Home 85 S. Main Street 26726 Julen Keyser, WV nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a, Part I, Enter the disease, or comp Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial LIVISION OF VITAL RECORDS, P.O. Box 68760, within 24 hours after death. Certificate be used to be a second of the 23d, Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth 2 Fetal death past 12 months? Pregnant at time of death Other (Specify) isigned by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available this certificate has been autopsy prior to completion of cause of performed? death? No Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? lospital: 1 Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes To the Funeral Director: After t completely filled in by the funeral 28a. Date of Injury Jul 10, 2007 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' Certification: Driver auto pick up collision 1510 hrs 1 Natural 1 Yes 2 ✔ No Pending 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) Route 220 North, Cumberland , MD (Specify) Interstate/Express Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie July 11, 2007 O.C.M.E. Č 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 D Patricia Aronica-Pollak MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

31. Date filed (Mpnth, Day, Year)

07-05302 David Wayne Bartlett

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	State of Maryland / Department of Health and Mental Hygiene
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edical Exami		David Wayne Bartlett 4a. Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of De-		4c. County of Death					
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Europel	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24I	Hrs. 8. Date of Birth(N	MM/DD/YYYY) 9. Birthplace (State or					
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hou hou is a		19a. Informant's Name/Relationship (Type, Print) Barbara A. Bartlett/Wife 19b. Mailing Address (Street and Number 119 West Main Street 119 West Main Stree	: Apt.6 Han	cock, MD 21750					
ore, MD ss I and 2 sho of Health and If item 27 is		20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 2	20c. Location - City or Town, State					
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important; If item 27 is n injury or other traumatic		crematory or other place)	7/13/07 B	Sig Pool, MD					
timent rtment rtant		4 Donation 5 Other Specify: FALKHEAD GETTICLET 9 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility		t Main Street					
Baltimore, MI permit. Pages I and 2 s Department of Health a Important; If item 27 Injury or other traum:	1 1	Grove Funeral Hom	ne.P.A. Har	cock.MD 21750-0368					
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lospita hours unera		4 Homicide	e, and due to the cause	e(s) and manner as stated.					
Jul 10, 2007 1302 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 29f. Location (Street and Number of For Town, State) 1300 Blk. Locher Road, Hancoc 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st. 29b. Signaptifie and title of certifier 29c. License number 29d. Date signed (h									
To To	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month, Day, Year)					
		Caral Hallar O.C.M.E.		July 11, 2007					
_		30. Name and address of person who completed cause of death (Item 23a)	21201						
5		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201						
	State								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** LOGER 13 Eu 28 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico KEGIONAL MEDICAL LENTER PALISBURY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 MM 2□ F 214.94.7198 Usuat Residence of Decedent Director 04-28-1964 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show oms 23a or 28a-f shor must be notified a MD1 ☐ Yes 2 XNo **Funeral Director** omersel Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21853 U.S.A 30589 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 'natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, important: If Item 27 is marked other than any injury or other traumatic event, the Maonce. Elementary/Secondary (0-12) College (1-4or 5+) (onstrution aboRER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Bailey STEVENSON KOBERT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Marshall mne, MD. 21853 30555 Civile Dr. Minass Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State John Wesley Comotory 07-07-2007 Frincess Anne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anthony E. Waren Funeral Home 30639 Hampdon Are Princess Anno, MD 11853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed QUKO Due to (or as a consequence of and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an was ... autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Hnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Injury 1 Tyes 2 🗌 No neral Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ElmStree

trar's Signature

Princess Anne MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

12137

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 04, 2007 Month **Physician** uly 1:170M Evelyn Virginia Briggs /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Faston Talbot Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2X□XF Director May 215-26-5714 5, 1930 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show iner must be notified at 1 TYes 2 X No MD Director Federalsburg Dorchester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21632 6330 Eldorado Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married **Maryland 21215-003**6 9 1 ☐ Yes 2√EMNo Specify: þ Specify: Black 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sylvester Evans Mary Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorsey Briggs, Jr./Son 6330 Eldorado Road, Federalsburg, MD 21632 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of the Important: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Federal Hill Cemetery 07/07/07 Federalsburg, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Holaile CFSP 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Rutered disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2☐ No 2 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 3 ☐ Sulcide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

15 rigg.

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State Registrar

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

HA.

29a. Certifier

J304

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

HO047522

John Appiott, MD

29d. Date signed (Month, Day, Year)

215100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day}007 **Physician** 30, 2:40 June AM Charles Murphy Beswick /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Ft. Washington Ft. Washington Hospital 9. Birthplace (State or Foreign f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day,)ec. 3, 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1**X** M 2□ F Days Hours Washington DC 213-38-1054 65 Dec. Director Usual Residence of Decedent 10c. City. Town or Location 10h. County 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2 No be notified Director Prince George's Brandywine Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with ō USA 20613 or items 23a 6105 Church Drive Pages 1 and 2 should be filed within 72 hours after death wont of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Used Car Sales Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Edwin Beswick Mary Jane Futch ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6105 Church Drive, Brandywine, MD 20613 Patrick M. Beswick - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Huntt Crematory 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07-02-2007 Waldorf, MD 4 Donation 5 Dother (Specify) 21. Signature of Fuseral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road |Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician liver disease or condition resulting in death) /Medical Due to (or as a consequence man creatic Cancer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner the death certificate be executed and Due to (or as a consequence of) burial-1 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) signed by the a ☐ Yes 2☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page ? certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day Year) Injury the Funeral Director: npletely filled in by the

P.O. Box 68760. Division or Vital Records, or Attending Physician: death. hours after To the Hospital within 24 hours a

Baltimore, Maryland 21215-0036

Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0051607 2007 30. Name and address of person of death (Item 23a) (Type, Print untre 12070

State Registrar

31. Date filed (Month, Day, Year)

JUL 05

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	Physici		1. Decedent's Name (First, Middle, Las Patricia	st)	Cham	bers					2. Date of De.		2007 Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give Somerford Place 5. Social Security Number 6. S	e at Whi	ttier	last hirthday			Location o	rick	9. Date of Bird		County of Dea	rick
	Funeral Director			M 2√2 F	71	last birthday) Yrs.	Months		Hours	Min.	8. Date of Bin Month, Da March	17,	1936	thplace (State or Foreign ountry): California
:	Ba-f show	Director	10a. State 10b. County Maryland Freder	rick	10c. Ci	ty, Town or Lo		derio	ck					10d. Inside City Limits
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Baltimore, Maryland 21215-0036	penint. Tages I and 2 should be filed within 7.2 hours after death win the marylan penint. Tages I and 2 should be filed to the filed then controlled to the filed then controlled to the filed then controlled to the filed to th	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4o 4	r 5+)	life.	kind of w	ork done d ise retired,	uring most	of workii	ng		Cind of Business	·
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imore	nent of He ant: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. F Sm:	Place of Dispo cometery, crer LthSbul	esition (Na matory or Cg C1	me of other place 'ema't (Bry .		18, 20		ocation - City of Smithsb	Town, State urg, Marylan
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8/60,	hysician and burial-transit the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or composhock, or heart failure. List only shock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a d.	s a consequence of a co	quence of):				cardiac o	respiratory at	rest, —		Approximate Interval Between Onget and Death
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rds, P.	n signed by	þ	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying	cause give	n in Part I.			obacco res 2	1 -	o the cause of death?
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	this certifica al director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	tient 2	ER/Outpatien	nt 3 🗆 D	Othe			Check only o		6 ☐ Other (Spe	ncify)
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DIVIS	를 를 드	Certification:	3 Suicide 6 Could not be determined	28e. Place of I	njury - At ho etc. (Specif		eet, factor	y, office		2	8f. Location (S City or Tox			ural Route Number,
	within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Ph 2 Medical Exam	ysician: To the bes iner: On the basis and manner s	of examina	wledge, death	occurred vestigation	at the tim n, in my op	e, date and inion, deat	d place, a	nd due to the d d at the time, d	cause(s date an) and manner a d place, and du	s stated. e to the cause(s)
ļ	To t	Σ	29b. Signature and title of certifier	More	l, m	D	29	D248					te signed (Mon. $1y$ 17 ,	
= 	Sta Registr		30. Name and address of person who described and address of person who described (Month, Day, Year) 1 9 2007	d, M.D.,	NAMES OF THE PERSON OF	Ridge	an a recons	. Rd.	, Sui	tc 1	04, Fre	der	ick, MD	21703

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 40 1. Decedent's Name (First, Middle, Last) 3. Time of Death Jul 7, 2007 Year **Physician** 2110 AM Catlett Clark /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Allegany Cumberland **Devlin Manor Nursing Home** 8. Date of Birth Month, Day, Sep 11, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**√** M 2□ F 1916 90 Director 234-44-6824 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Wilev Ford WV Mineral 1 ☐ Yes X ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 26767 Rt. 1 Box 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2☐No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. **7 Is marked other than "r** Elementary/Secondary (0-12) College (1-4or 5+) Shanholtz Orchard Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nannie Pearl (Sherrard) Catlett Oscar Catlett ౖ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 1 Box 23 Wiley Ford WV 26767 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traum daughter Nellie Deahl 20b. Place of Disposition (Name of cemetery, crematory or other place)
Levels Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/9/2007 WW Levels 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fur eral Service Licensee ^{22. Name} and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Phiter the disease, or complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Burg /Medical Due to (as a consequence of): Seven Examiner Howh Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes _ 2D No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this after death. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a e Funeral I 102 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 24 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENTIAVE., CUMBERLAND, MD 21502 Ce as GUPTA, M.D 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Physician Phys	23233							
Modeled Committee Commit	3. Time of Death							
Examiner As Feight Name (**Interfactions give street and number) Activity Name (**In	11:30 P							
S. Social Security Number 6. Sec 12,M 2 7. Age (In rys. star bitmay) 3 Bertin 10 10 10 10 10 10 10 1								
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Physician //Medical Examiner 23a. Part I. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Physician //Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Final disease or conditions, if any, leading to immediate cause (Final disease or conditions, if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) if any, leading to immediate cause (Final disease or conditions) in the total cause (Final disease or conditions) in the underlying cause given in Part I. 23b. Did tobacco use contribute to any performed? 24a. Was an autopsy performed? 24b. We are a consequence of): 24a. Was an autopsy performed? 25b. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1								
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2 1 Yes 2 No								
1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident civestigation sinvestigation and suicide 6 Could not be determined by the state of the								
2 Accident Street and Number or Rural Street and								
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building, etc. (Specify) City or Town, State)								
So the control of the	ed.							
29a. Certifier (Check only one)	ie cause(s)							
and manner stated. 29c. License number 29d. Date signed (Month, D	y, Year)							
D 48098 6/24/07								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
Vijay Karumbunathan, M.D. 201 Hall Highway - Crisfield, Maryland 21817								
State								

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended 19a,7/13/07,LDB,DOR Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DISE June 29 opper 2007 9:30 PM /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Genesis HealthCare - The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2EF 68-44-5040 5 Pennsylvania Director July 28, 1954 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. fnside City Limits 28a-f ehov 1 Ves 2 No Completed by Funeral Director =aston Talbot 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 401over brook 160 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Medical Evandon 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Copper Technician 12 t of Health and Mental Hygie If Item 27 Is marked other I other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sampson 2 arroll Johnson SR. atherine 19a. Informant's Name/Relationship (Type, Print) Matthews 196. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eloise 401-Doverbrook St. Easton, Maryland 21601 atherine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20 Location - City or Town, State 1 12 Burial 2 □ Cremation 3 □ Removal from State ö Sandtown Cemetery Important: If any Injury or once. 7/5/07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address Facility Henry Funeral Home, P.A. 510 washington St. Combridge 23a. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fntervaf Between Onset and Death Immediate Cause (Finaf primome o **Physician** disease or condition resulting in death) yaans /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? (es 2 No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes > No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? After t 28d. Describe how injury occurred Hospital or Attending P Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of parson who compared cause of death (Item 23a) (Type, Print) GIC MD HMANS 47 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 23:45 M **Physician** 6 7 7007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Ame (If not institution, give street and number) Examiner Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You Oct. 22, 7. Age (In yrs. last birthday) 9. Birthplace (Sta **Funeral** Year Days Maryland Months Hours 1**X** M 2□ F 214-76-5829 Yrs. 43 1963 Director Usual Besidence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Queen Anne's Grasonville 1 ☐ Yes 2 No ns 23a or 28a-f st must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21638 243 Timber Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify. ģ 3 Widowed 4 Divorced Completed the Medical E 16b. Kind of Business/Industry Childrens 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Monce. Mental Health Psychotherapist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond August Cadden, Sr. Joan Marie Hurd ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara A. Cadden/Wife Grasonville, MD 21638 243 Timber Lane 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition July 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 2007 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. 21. Signature of Funeral Service Licenses Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CPFS **Physician** /Medical sequence of) Due to (or as a co Examiner Perforated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed! Yes 2 No 25. Was case referre o medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature Ind t 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Be HiLare MD 2120 5. Green (Jibbe) 31. Date filed (Month, Day, Year) gistrar's Signature State JUL 0 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 29M 200 nee /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ Months Hours 25 maryland -67 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ifem 27 is marked other than "natural" -- " any nighty or other traumatic exercises." 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give / Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2□ No Specify Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be ONtreras Jr. 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jr. SAlisbury, md 21801 (father) Trevas 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐ Removal from State 7-9-07 Delmarva: 4 ☐ Donation 5 ☐ Other (Specify) of Delmar, Delaware Bennie Smithone 917 W. Isabella St SALISBURY, md 21801 23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between nset and Death **Physician** shoul disease or condition resulting in death) /Medical Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): inding physician ause as the burial 68760, Physician/Medical Box (IF FÉMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u in the past 12 months? 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at id be detached fo o 9 ☐ Unknow م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy erformed' certificate or Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral Manner of Deal 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending (Month, Day Natural 5 Pending investigation 1 Avaturai 2 Accident nours after death. Ineral Director: Aft y filled in by the fur 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a certifying physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar 29b. Signature and titl

31. Date filed (Month, Day,

Year)

5

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

on who completed cause of death (Item 23a) (Type, Print

(000 32. Registrar's Signature

			State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death	ental Hygie	ene	
					. No.?) () 7	23237
Æ	Physicia /Medic	an		2. Date of Death Month JULY 14	, 2007 Year	3. Time of Death '
y .	Examin	-	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	
			MORNINGSIDE HOUSE WALDORF		CHARLES	
Н	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bir 1917 VA	thplace (State or Foreign ountry)
	pu ,	9	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryla f show ied at	jo	10a. State 10b. County 10c. City, Town or Location WALDORF			1 ☐ Yes No
	or 28a-	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	ountry?
	23a c	a [70 VILLAGE STREET 20601	U	.S.A.	
	ems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto Forces)	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the M. dr.al Examiner must be notified at once.	by	1			HITE
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Ξ̈́	and 2		SUSAN STENNETT KNOTT-DAUGHTER 14655 BAR HARB	OR CT.	SWANN P	Γ.,MD.
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Baltimore,	Рад tment tant: I		Member of Disposition Memb	7-18-07	ANNADA	LE, VA.
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee M0 0 4 7 9 22. Name and Address of Facility RAYMOND FUNERAL LA PLATA, MD. 20	SERVIC		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.		st,	Approximate Interval Between
Y	Physician /Medical		Immediate Cause (Final disease or confident) a. DEMENTO A AZZILIZMI resulting in death) a.	423, T.	y pe	Onset and Death
	Examiner		Due to (or as a consequence or):			
17	ed sit	iner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that bit learning to make the conditions of the			
<u> </u>	execut n and ial-trar	Examiner	that initiated events c			
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical	d			
_	ertifica ing ph e as th		IF FEMALE:		1	
Box	death cert	ian/	23b. Was decedent pregnant in the past 12 months?		23d. Date of de Month	elivery Day Year
P.0.	D O D	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
	that bed by deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
or Vital Records,	law requires that the as been signed by th 2 should be detache			1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
ecc	has bei	Completed		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u>=</u>	The sate h	Com		perform 1⊟ Yes 2	ed? death?	_
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital: Description of Death Control of Death	(Check only one,		
o	Phys this al dir	<u>۲</u>	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Hor	me 5 Residen 28d. Describe how	ice 6 Other (Spe	ecify)
Ou	ding h. After fune	tion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 4 Work? 28c. Injury at Work? 1 Yes 2 No	200. Describe nov	rinjury occurred	
Division	Atten r deat ector: by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury At home, farm, street, factory, office 2		eet and Number or F	Tural Route Number,
Ď	tal or s after al Dir	Certification:	4 Homicide Building, etc. (Specity)	City or Town,	State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the car red at the time, da	use(s) and manner a te and place, and du	is stated. ie to the cause(s)
	To th Withir To th COMP	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mon	ith, Day, Year)
			D42509		1/15	17
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ME, NOLTRY 12070 OLD MINE CIR HIIU WILOURF	MITTE	m	,
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	MLY Z	160-	
	اد Registi		111 1 9 7007 Robert 18 Sough			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	tte or waryland		ificate of I			g. No.		00000
-		15	Decedent's Name (First, Middle, Last)			. ,,-		2. Date of Death Month		Year	3. Time of Death U
	Physicia /Medic		CHARLES JUNIO	IS DAVIS				JULY		2007	OCAM
	Examin		ta. Facility Name (If not institution, give street	4 11 4 =		4b. City, Town, or	Location of Death	•	4c. County		
*	villa and a second	+	Southern Maryland H	tospital Cer		Clinton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Prince	e C	ace (State or Foreign
A.	Funeral		5. Social Security Number 6. Sex 1 M M 2	7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	Month, Day,		Counti	y) .
4	Director		Usual Residence of Decedent	65				April 20	,1992	Virgi	inia
	yland yland at		10a. State 10b. County	10c. City, T	own or Loca	ition				10	d. Inside City Limits
	e Mar	cto	Maryland Prince Ge	eorges Cli	nton						1 Tes 2 No
	or 28	Dire	10e. Street and Number	,		10f. Zip Code		10	g. Citizen of	What Count	ry?
	ath w	Funeral Director	9211 Stuart Lan	e	140 144	2073		asifu Van av Na	USA	ce - America	n Indian
	items ner n	ű,	Ar	as Decedent Ever in U.S. med Forces?	ls. vv	Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		ck, White, e	
36	ırs afi Il", or xami	by F	3 ☐ Widowed 4 ☐ Divorced Ye	∃Yes 2KLNo Yes, Give ear or Dates:	1[∐Yes 2. No	Specify:		Speci	r. Blo	ck
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ted	15. Decedent's Education (Specify only highest grade com	nlotad) 1	6a. Decede	nt's Usual Occup	ation	king	16b. Kind of E		
218	thin 7 e. an "n Med	Completed	Elementary/Secondary (0-12) Co	llege (1-4or 5+)			during most of work	I	1		
21	ed wi ygien yer th	Co	11+h		Cons	truction			Cons		100
E P	be fill tal H d oth even	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, N		, '	
<u>5</u>	nould narke	2	LYNWOOD DAVI	S (at)	10h Mailing	Address (Street	HCLYF and Number or Ru		Bat		Coda)
Maryland	D = 1 = 0		19a. Informant's Name/Relationship (Type. Pr Christine Easter/						-		20904
d)	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. If Health and Mental Hygiene "natural", or items 23a or 28a-f show flem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	20b. Plac	e of Disposi	tion (Name of atory or other place		Date :	20c. Location	- City or Tov	vn, State
و	ages ent of it: If I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)					10 2007	Black.	tone	10
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee	VAC	22.	Name and Addre	ss of Facility	E. HAWKE	3 450A	Fune	VA crai itome
Ä	permir Depar Impor any ir once.		muchael w Hou	when 044.			St F				
Ę			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	is that caused the death. I	Do not enter	the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Acute Myou	unchal	Interct	m				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen		А	40				
		7	Sequentially list conditions, b	Athensilen Due to (or as a consequen	nc u	monay "	ty Dises	ч		-	
1.6	nsit	Examiner	S yes fally let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ma	tificate be executed g phystcian and as the burial-transit	Exai	resulting in death) Last	Due to (or as a consequen	nce of):						
68760,	icate be ex physician the buria		d								
89	rtifica ng ph as th	Med	IF FEMALE:	-							
Вох	eath cer attendin for use	an/I	23b. Was decedent pregnant in the past 12 months?	yes, outcome pf pregnancy Live birth 2 Fetal de	eath 3 🗆 🛭	Ectopic pregnancy	/			ate of deliver	y Day Year
0.	ne deg the at hed fo	Physician/Medical	1 Van 2 No	□Pregnant at time of deat □Unknown	th 5 🗆 1	Other (specify) _					
P.O.	uires that the de signed by the a Id be detached f		Part II. Other significant conditions contribut	ing to death but not resultir	ng in the und	derlying cause giv	en in Part I.	23e. Did tob	acco use cor	ntribute to the	e cause of death?
ds,	signe signe d be	d by	Enterobacter cloacae &	saterinia				1 □ Ye	s 2 No	3 🗌 Proba	ably 4 □Unknown
S	w req been shou	lete						24a. Was a	n 24b	. Were autor	sv findings available
Be	he la e has age 2	Completed						autops perforr	ned?//	death?	sy findings available apletion of cause of
ta	an: T tificat tor, pa		25. Was case referred to medical				26. Place of Dea	th (Check only on	e)	1 🗆 Yes	2 NO
<u> </u>	ysici is cer direc	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospita	al: 1 Inpatient 2 ☐ ER	VOutpatient	3□ DOA Oth	er: 4 D Nursing H	ome 5 ☐ Reside	ence 6 🗆 Ot	her (Specify)
0	ng Ph fter th neral		27. Manner of Death 28 1 ☑ Natural 5 ☐ Pending	a. Date of Injury 28 (Month, Day Year)	3b. Time of Injury	28c. Injui Wor	y at k?	28d. Describe ho	w injury occu	rred	
Si	tendii eath. or: A	satic	2 Accident investigation				Yes 2 ☐ No				
Division or Vital Records,	or Att	Certification:	4 Homicide determined	e. Place of injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Num n, State)	ber or Rural	Route Number,
	pital ours a eral I filled		29a. Certifier 1 Certifying Physiclan	To the best of my knowle	edge death	occurred at the ti	me date and place	and due to the co	ause(s) and n	nanner as st	ated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within the At hours after death. To the At hours after death. To the Funeral after death. To please the Funeral prector. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Examiner: C	On the basis of examination and manner stated.	n and/or inve	estigation, in my	opinion, death occu	rred at the time, d	ate and place	, and due to	the cause(s)
	To the within To the somple	Me	29b. Signature and title of certified			29c. Licens	e number	2	9d. Date sign	ed (Month, L	Day, Year)
			* Waln	MO		Doc	55120		July 16	2007)
	Λ		30. Name and address of person who complet		3a) (Type, P				1		
	2		hickord Palmer mo	is a cause of death (Item 23) 13 2 5 4 mm e	m ave	one St.	lute 310	Winshin	jun Do	2003	۷
	Sta Registi		31. Date filed (Month, Day, Year) 1 9 2007	32. Hegistrar's Signatur	Service .	8					
	negisti 	aı	JOL T & EGG! LEG	Section of							

State Registrar

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29b. Signature and title of certifier

31. Date filed (Mor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William F. Badan William F. 9 Sa

9584 Paul Street, Broast

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 17 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7, 2007 July 10:45A M Theodore Jack Durland, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Harford Harford Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**2** M 2□ F Yrs. 10/12/1929 77 Pennsylvania Director 164-24-0013 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Cecil Conowingo 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code USA 21918 761 Ragan Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ½TYss 2 □ No If Yes, Give Year or Dates: 1948–69 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Š 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 US Army Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary McGinty Theodore J. Durland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 Chapel Road, Havre de Grace, MD 21078 Michael Zellman (caretaker) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Depertment of Important: if any injury or once. RA Ferris & Co., Inc 07/9/2007 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Zellman Mitchell Smith Funeral Home 123 S. Washington St., Havre de Grace, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meumonia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

To the Hospital within 24 hours e To the Funeral I 100 State

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Jurland, Theodore

2 should be for and Mental P

Pages 1 and 2 sl ment of Health and ant: If itsm 27 is r

Kevin 31. Date filed (Month, Day, Year) JUL 1 9 2007

29b. Signature and title of certifier

29a. Certifie (Check only one)

> CYNCH MD . Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D35012

29d. Date signed (Month, Day, Year)

North Ave Bel Air, Md. 21014

Registrar

			For State Registrar	State of Mary		artment of H rtificate of L			giene Reg. No.		
	Physicia	an	Decedent's Name (First, Middle, Last) JOHN E		VIDSON	CD		2. Date of De	Day Year		
*	/Medic	ai -	4a. Facility Name (If not institution, give			SR 4b. Citv. Town, or	Location of Death	JULY	9, 2007 4c. County of De	0:33F	
	Examin	er	FREDERICK MEMOR		'AL	FREDERI			FREDERICK		
	Funeral Director		5. Social Security Number 6. Sep. 236-32-1640		n yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da OCT 2	9. B y, Year) 7 1921	irthplace (State or Foreign Country) VA	
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits	
	Maryl -f sho fied a	to	MD MONTGO	MERY	DICKE	RSON				1 Yes 2 □ No	
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 22401 NICHOLS	ON FARM R	D.	10f. Zip Code 20842	2		10g. Citizen of What 0	Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	Ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black, Wr	nerican Indian, nite, etc. IHITE	
Maryland 21215-0036	within 72 ho ene. than "natu i he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) ODIAN			16b. Kind of Busines MONTGOME PUBLIC S	RY CO.	
1d 2	il Hygi other /ent, t	Be Co	17. Father's Name (First, Middle, Last)	i sime	I		18. Mother's Name	e (First, Middle,	Maiden Surname)		
ylar	ould be Ments arked aric ev	To E	ROBERT LEONARD				NANCY				
	and 2 sho salth and n 27 is m er traum		19a. Informant's Name/Relationship (Ty DOROTHY DAVIDSO	N / SPOUS	E 2240	1 NICHO	LSON FAR	RM RD.	, DICKERS		
altimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	20b. Place of Dispo cemetery, cree MONOCAC	matory or other plac	ce) ¦	Date I 4 / 0 7	20c. Location - City of BEALLSVI	ŕ	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens			2. Name and Addres HILTON P.O. BO	FUNERAL X 86, BA	ARNESV	ILLE, MD	20838	
	Physician	i n	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	2.7	e death. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (as a co							
Į.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on Injury that initiated events	Due to (or as a co	onsequence of):						
B	ecuted and -transii	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a co	ansequence of):						
68760,	ficate be executed physician and s the burial-transit	edical E		d	51135que.1105 517.						
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 [4 ☐ Pregnant at tirr 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnancy □ Other (specify) _	y	nev	23d. Date of o Month	delivery Day Year	
rds, P	quires that n signed by	by	Part II. Other significant conditions co		ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did t		to the cause of death? Probably 4 Wunknown	
Division or Vital Records,	ysician: The law requir is certificate has been si director, page 2 should I	Completed						1□ Yes	psy prior t death 2 No 1 Y	autopsy findings available o completion of cause of ? es 2 No	
Zii.	sician; Th certificate irector, pag	Be c	25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpatier	nt 3 DOA Oth	26. Place of Deat		one) idence 6 □Other (S	nacif d	
on or	iding Phy th. : After this funeral d	tion: To	27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time o	f 28c. Injur			how injury occurred	эөсну)	
Divisi	al or Atter s after dea I Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (- At home, farm, str Specify)	reet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,	
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, t	Medical C		sician: To the best of r iner: On the basis of ex and manner stated	amination and/or in						
	To the within To the comp	Me	29b. Signature and title of certification	//		29c. Licens			29d. Date signed (Mo		
)			· Call	C KIL),		26499	1	7-12	-07	
	5		RONA Miller	MD P.C	O BOX Z	210. MT	. AIRY	MD.	2177)		
	Sta Regist		31. Date filed (Month, Day, Year)	2. Registrar's	Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			_ For	State of N	/larylan	d / Depa	artmen	t of H	ealth a	and M	ental Hy	giene	3		
			1 - State Registrar			Cei	rtificate	e of L	Death			Reg. No.	1117	232	44
	Physici	an	1. Decedent's Name (First, Middle,								Date of De Month	Day		3. Time of	Death
	/Medic	cal	John Washingt 4a. Facility Name (If not institution,				4h City	Town or	Location o	of Death	6	29	07 County of Dea	5:45	р
	Examin	ier	Fairland Nurs	-	,		, ,		Spri				ntgomer		
F	uneral		5. Social Security Number	6. Sex 7.	Age (In yrs. i		If Under Months		If Under a		8. Date of Bir (Month, Da	th y, Year)	9. Bir	thplace (State o	or Foreign
	irector		579-44-6298 Usual Residence of Decedent	1√ M 2□ F	75	Yrs.		,-			6/26/1	932		hingtor	ı,DC
land	ow at		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside Ci	ity Limits
Man	a-f sh	ctor	MD P.G.		Mit	chelle	ville	:						M∏Yes	2 🗌 No
ith th	or 28 se no	Director	10e. Street and Number				10f. Zip						zen of What Co	ountry?	
eath w	is 23a must	Funeral	1607 Fairlakes	Place 12. Was Decede	nt Ever in II	S 13 V	207		snanic Orig	gin? (Sne	ocify Ves or No		SA 14. Race - Ame	erican Indian.	
offer d	r item	Fun	11. Marital Status 1 ☐ Never Married	Armed Force	s? TiNo					i, Puerto	ecify Yes or No Rican, etc.)		Black, Whit	te, etc.	
ours a	ral", o Exan	<u>م</u>	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	3:		1 ☐ Yes 2	ZXLI No	Specify:				Specify: B1	.ack	
12 h	"natu adical	Completed	15. Decedent' (Specify only highes			16a. Deced	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation Juring most	t of worki	ng	16b. Kir	nd of Business	/Industry	
with it	than the Me	E G	Elementary/Secondary (0-12)	College (1-4c		Buildi						nri	ivate		
be filled	other vent, 1	BeC	17. Father's Name (First, Middle, L	*							(First, Middle,				
2 should be filed within 72 hours after death with the Maryland	arked atic e	Į.	John Daughtry						Ethe1						
VIAI 12 sh	Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh								al Route Numb				
1 and	tem 2		Wanda Daughtry, 20a. Method of Disposition	Wife	20b. P	1607 lace of Dispo	Fair sition (Nan	lake ne of	s Pla	ice,	Mitche Date	11evi 20c. Loc	L11e,MD cation - City or	20721 Town, State	
Pages	it: If i		1 ABurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		te i	emetery, crer • Linc	-			/6/0	7	Bren	itwood,	MD	
Dalling	importa any Inju		21. Signature of Funeral Service L	icensee M	111.						Linco				
0 82	2 E 29		· whi	mu	u						. Brent		1,MD 20		
			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	omplications that caus	ine deatr	n. Do not ent	er the mod	e or ayını	g, such as	cardiac c	or respiratory a	rrest,		Approximat Interval Bet Onset and	tween
	/sician ledical		disease or condition resulting in death)		stive as a consequ	Heart uence of):	Fail	ure							
Ex	aminer		Cognoptially list conditions	b	·	,									
p	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Each uncertaining Cause (Disease or injury that initiated events	Due to (or	as a consequ	uence of):									
xecut	and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a consequ	uence of):									
te be ex	hysician and the burial-transit	ical		d											
rtificat	ng ph) as th		IF FEMALE:												
ath cert	ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birth	2 ☐ Feta	Ideath 3	Ectopic pr					2	3d. Date of de Month	,	Year
the de	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknowr		eath 5L	Other (sp	ecify)						,	
s that	ned by e deta	by Ph	Part II. Other significant conditio	ns contributing to death	but not resu	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did t	obacco u	se contribute t	o the cause of o	death?
v requires	en sig ould b		Diabetes								1 🗆	Yes 2X	No 3∏P	robably 4 🔲	Jnknown
law r	as be	Completed	Coronary Art	ery Diseas	e				<u>-</u>		24a. Was autoj	osv	prior to	utopsy findings completion of c	available ause of
ב יי	icate } r, pag										perfo 1□ Yes		death? 1 ☐ Yes	s 2 No	
VII.di	s certil lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpatier	nt 3□ DC	Othe			n <i>(Check only c</i> me 5 ☐ Resi		S ∏Other (Sn	acifu)	
2 g	ter thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of I		28b. Time of		8c. Injury Work			28d. Describe			ony)	
SIOIS	the fu	catic	2 Accident investig	ation			М	10,	Yes 2□I						
lor At	Direct Direct In by	Certification:	4 ☐ Homicide determi	26e. Flace of	etc. (Specif		eet, factory	, office			28f. Location (3 City or Tol			lural Route Nun	iber,
spital	ineral y filled	alC	29a. Certifier 1 Certifying	Physician: To the be	st of my kno	wledge, deatl	h occurred	at the tin	ne, date an	d place,	and due to the	cause(s)	and manner a	s stated.	
DIVISION OF VITAL INCIDENCE DOX 00/00, The Hospital Programme The law requires that the death certificate be executed in the death certificate be executed.	within 24 hours are ocean; the this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	ledical	one)	examiner: On the basis and manner		tion and/or in				tn occuri	red at the time,				3)
101	10	Ž	29b. Signature and title of certifier					. License 58962					e signed (Mon		
1			30. Name and address of person v	yho com la sac a	f death /ltom	23a\ /Tune		0902	_			July	5, 200)/	
_(2/	15 3	Shashank G. P	atel 1811	21 Geo	roia A	We S	Suite	103	. 01:	ney,MD	2083	2		
L	Sta	-	31. Date filed (Month, Day, Year) 0 5 2007		strar's Signa	ture	,			, .					
	Registr	rar	JUL O O ZUUI	Delen	10.	July									

			_ State	State of Maryland / De	epartment of Heal Certificate of Dea			000	5 00015		
			Registrar 1. Decedent's Name (First, Middle, Last)		erinicale of Dea	alli	2. Date of Dea	eg. No.	3. Time of Death		
	Physic /Medi		James Junior	Edwards, Jr.			Month June	_	ear		
	Exami		4a. Facility Name (If not institution, give si		4b. City, Town, or Loca	ation of Death	1	4c. County of			
			113 Flower Street,	Apt. 25	Berlin			Worce	ster		
	Funeral		5. Social Security Number 6. Sex	M 2 ☐ F 7. Age (In yrs. last birtho	Months Days Ho	Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day) Feb. 17,	Year) 9	. Birthplace (State or Foreign Country)		
	Director		Usual Residence of Decedent	77 Yrs			Feb. 17,	1930 V	'irginia		
	ryland how		10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits		
	Ba-f e	cto	Maryland Worcester	Berlin					1 X Yes 2 □ No		
	with the or 2 to 2 to 2	Dire	10e. Street and Number	0.5	10f. Zip Code		1	0g. Citizen of Wha	at Country?		
	filed within 72 hours after death with the Maryland Hyglene. tither then "netural", or items 23a or 28a-f ehow int, the Medical Examiner must be notified at	Funeral Director	113 Flower St., Apt.		21811	- 0-1-1-2/0-		USA			
(0	r iten	Fun	1 □ Never Married 2 □ Married	Armed Forces? 1 XYes 2 No	 Was Decedent of Hispani If Yes, specify Cuban, Me 	exican, Puerto	Rican, etc.)		American Indian, White, etc.		
8	ral', o	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give 1948-52 Year or Dates:	1 ☐ Yes 2 🔀 No Spe	ecify:		Specify:	Black		
<u>7</u>	72 h	Completed	15. Decedent's Educa (Specify only highest grade	completed) (G	ecedent's Usual Occupation ive kind of work done during	most of work	ina	16b. Kind of Busin	ness/Industry		
7	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired)						
2	filed Hygi other		7th 17. Father's Name (First, Middle, Last)	labo		Mother's Nam		HOIIMan' Maiden Sumame)	s Cleaners		
<u>la</u>	Aental Aental rked o	To Be	Oather Stewart				Edward	,			
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "netural; or items 23s or 28s-f show aumatic event, the Madical Examiner must be notified at		19a. Informant's Name/Relationship (Type	9, <i>Print</i>) 19b. M	ailing Address (Street and N				ate, Zip Code)		
	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatic e		Sheila Hall/ sister		Foote St., N	I.E., W	ashington	, D.C. 20	0019		
Baltimore,	Pages 1 nent of H int: If ite iry or ott		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Re	moval from State 20b. Place of Discemetery, of	sposition (Name of crematory or other place)	ļ	1	20c. Location - Cit			
	it. Pa intmen intent: njury		4 □ Donation 5 □ Other (Specify) 21 □ Fineral Service Licensee	MD V.A	. Cemetery			Hurlock,	-		
Ba	permit. Page Department Important: If eny injury or once.		A. III. B	111-					Salisbury, MD		
			23a. Part1. Enter the disease, or complication		JOLLEY MEMO				21801 Approximate		
Υ	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition								
de.	/Medical		resulting in death)	Due to (or as a consequence of):					JEUISZAL YZS		
	Examiner		Sequentially list conditions, b.								
	led sit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):							
	execunand and al-trar	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence of):							
09/89	ficate be executed physicien and is the burial-transit	cal	L _d .								
_		edi	IF FEMALE:								
XOA	death certif ie attending ad for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	t. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy			23d. Date of	,		
	0 0	ysic	1 Yes 2 No		5 Other (specify)			Month	Day Year		
J.	requires that the de een signed by the a nould be detached f	/ Ph	Part II. Other significant conditions contr	buting to death but not resulting in the	underlying cause given in P	Part I.	23e. Did tob	acco use contribut	te to the cause of death?		
ecords,	8 50	d by			, , , , , , , , , , , , , , , , , , , ,				Probably 4 Munknown		
ဂ လ		olete					24a. Was an	24h Wer	e autopsy findings available		
ř	rsician: The law s certificate has b lirector, page 2 s	Completed					autopsy	prior deat	r to completion of cause of th?		
VITAI H	cian: ertifica	Bec	25. Was case referred to medical examiner?		26. F	Place of Death	1 ☐ Yes 2		Yes 2□ No		
0	Shysic this call dire	ို	1AYes 2 No Hos	spital: 1 Inpatient 2 ER/Outpat		☐ Nursing Ho	me 5 KReside	nce 6 Other (5	Specify)		
	ding f h. After funer	tion;	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	Work?		28d. Describe ho	w injury occurred			
UNISION	deati ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm,	M 1 Yes :		28f Location /Str	ant and Number o	r Rural Route Number.		
5	al or setter	Certification;	4 Homicide determined	building, etc. (Specify)	stroot, tactory, onlog		City or Town,	State)	r Hurai Houle Number,		
	ospit hours unera ly fille		29a. Certifier 1 Cartifying Physic (Check only 2 Check only	ian: To the best of my knowledge, de	ath occurred at the time, date	te and place,	and due to the ca	use(s) and manne	or as stated.		
	To the Hospital or Attending Physician: which 24 hours elder deals resemble to the Funeral Director; Atten this certification of the funeral director, completely filled in by the funeral director,	fedical		r: On the basis of examination and/or and manner stated.			ed at the time, da	te and place, and	due to the cause(s)		
	5 th C 12	2	29b. Signature and title of certifier	1 - 1 ×	29c. License numb		29	d. Date signed (M			
	LATA			worth, M.S.	D 06.	141		07-0	5-07		
Ì	TIVA		30. Name and address of person who com				<i>e</i> .	.17. 11	4		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature	ZUS SNU	DW ST	JNO:	VHILL, M	D. 2/863		
	Registra	ar	JUL 0 5 2007	Deliver 15 14							

			1 For State Registrar	State of Marylar	nd / Department of		ental Hygiene	111111111111111111111111111111111111111	Ö
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	nomas Fi	ountain		2. Date of Death Month Day	3. Time of Deat	th Ø M
	Examinum Funeral Director		011-10 000	anc	Crist			One. 5 c + 9. Birthplace (State or Ford Country) Mary iand	eign
	the Maryland 28a-f ehow	tor	Usuel Residence of Decedent 10a. State 10b. County Somers	10c. C	ity, Town or Location ristield			10d. Inside City Lim	
	ath with the s 23s or 28 wat be not	Funeral Director		Ne	10f. Zip Code	817	Ur	zen of Whal Country? Dited State	5
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 Ie marked other than "natural", or itams 23s or 28s-f ehow other traumatic event, the Medical Ever it well most be notified at	b	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 May 2 □ No If Yes, Give Year or Dates:	If Yes, specify C	of Hispanic Origin? (Specuban, Mexican, Puerto R No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, While, etc. Specify: BLACK	
21215-0036	filed within 72 hours Hygiene. wher then "neturel", int, it o Medic: Eve	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occ (Give kmd of work doi life. DO NOT use ret	ne during most of working	Se Calo	of Business/Industry elf-Employed linet making	1
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event, ILe Mi	To Be (17. Father's Name (First, Middle, Last) George Tho	mas Foun	tain SR.	Gertru	First, Middle, Maiden	Sumame) J	
	ges 1 and 2 sho t of Health and If item 27 I e ma or other trauma		Ruth Fountain 20a. Method of Disposition	1 (wife)	Place of Disposition (Name of	ne Crist	held, me	21817 cation - City or Town, Slate	
Baltimore	permit. Pages Department of I Important: If it any injury or o		Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service, License	Ma Ma	tyland Ve terans 22. Name and Ado	(pin. 1/9	107 Bec	Jah Marylar Isabella 1 St	rd
	80 E 2 9	VI S	23a. Part 1. Enter the disease, or compile shock, or heart failure. List only on	cations that caused the deal e cause on each line.	th. Do not enter the mode of d	ral Home tying, such as cardiac or	Sali's respiratory arrest,	bury, md 2198 Approximate Interval Between	/
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulling in death)	Due to (or as a consec	THEUCO	m A		Onset and Death	7
	cuted nd iransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentifying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):				
8760,	icate be executed physician and s the burial-transit	cal	resulting in death) Last	Due to (or as a conseq	quence of):				
.O. Box 6	The law requires that the death certificate be executed tto has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 Ectopic pregnar		2	3d. Date of delivery Month Day Year	
rds, P.	w requires that been signed b should be deta	by	Part II. Dther significent conditions con	tributing to death but not res	sulling in the underlying cause	given in Part I.		se contribute to the cause of death? No 3 Probably 4 Unknow	
		Completed					24a. Was an autopsy performed?	24b. Were autopsy findings availal prior to completion of cause of death? 1 ☐ Yes 2 ☑ No	ble
Z:	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/OutpatienI 3 DOA	26. Place of Death	41		
	ding Phy h. After this funeral c	 	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. In	jury at 28	9 5√ Residence 6 d. Describe how injury		-
jor	Attending r death. sctor: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(WOIIII, Day Year)		/ork? □ Yes 2 □ No			
É	Dist.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specif			City or Town, State)		
	e Hospital 24 hours a Funeral I etely filled	ledical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death occurred at the tion and/or investigation, in my	time, date and place, an opinion, death occurred	d due to the cause(s) a lat the time, date and	and manner as stated. place, and due to the cause(s)	
-a -c/	To the I	Me	29b. Signa and title of certifier	22.2	29c. Lice	nse number	29d. Date	signed (Month, Day, Year)	
/	m.	1	Mubrael C	tho AD	1	578/-	2	15/07	
la	IVA		30. Name and address of person who cor	npleted cause of death (Iten	n 23a) (Type, Print)	toll the	May C	Mistald m	2
	Sta Registr		31. Date filed (Month Pay, Year) 5 20	07 32. Degistrar's Signa		0		21817	-

			Registrar	Ce	rtificate of	Death	Reg. I	No.	23217	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Fcui	CICEY		Day Year 23 3\ M			
	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Death		
			Anne Arundel Medical Cente		Annapo1	is	Pate of Birth Month, Day, Yea	Anne Aruno		
1	Funeral		10 M 2 T F	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min. 8. D	ate of Birth Month, Day, Yes	ar) 9. Birthp Cou 1913 Wasi	place (State or Foreign ntry) nington D.C	
	Director		212-38-8120 9 Usual Residence of Decedent	Yrs.		00	Ct. 5,	1915 Wasi	ington D.C	
	land ow at		10a. State 10b. County	10c. City, Town or Lo	ocation				Od. Inside City Limits	
	Mary I-f sh	tor	Maryland Anne Arundel	Anna	polis			1 □ Yes 2√√No		
	in the or 28s	jrec	10e. Street and Number		10f. Zip Code		10g. (Citizen of What Cou	ntry?	
	th wil	Funeral Director	7101 Bay Front Drive Uni	t 108	2140	3	1	United Sta	ates	
	r dea	nue	11. Marital Status 12. Was Decedent Armed Forces'	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specify ` an, Mexican, Puerto Rical	Yes or No- n, etc.)	14. Race - Americ Black, White,		
36	be filed within 72 hours after death with the Maryland ntal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married ※※※ Married XXX Yes 2☐ 1 Yes, Give Year or Dates:	No 1931- 1972	1 ☐ Yes XX No	Specify:		Specify: Wh:	ite	
21215-0036	hour tural	Completed by	15. Decedent's Education	16a. Dece	edent's Usual Occup	ation	16b	. Kind of Business/In	dustry	
215	nin 72 in "ni Medi	plet	(Specify only highest grade completed)	(Give life.	e kind of work done DO NOT use retired	during most of working d)				
212		mo;	Elementary/Secondary (0-12) College (1-4or 5+		Rear A	dmira1		U.S. Na	avy	
nd	al Hygid I other	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name (First		len Surname)		
<u>ya</u>	should be filed and Mental Hygi s marked other umatic event, t	2	Isaac Newton Fluckey			Luella Sno				
Maryland	0 0 0		19a. Informant's Name/Relationship (Type. Print)			and Number or Rural Ro			o Code) s, MD 21403	
	1 and 2 Health tem 27 I		Eleanor M. Fluckey / Wife 20a. Method of Disposition					Location - City or T		
آور	0 0		1 ☐ Burial	9	osition (Name of ematory or other place	i i		·		
Baltimore,	permit. Pag Department Important: I any Injury o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		re Cremat 22. Name and Addre	Company of the Compan		ltimore, l	uaryiand al Home,Inc	
Ba	permit. Departm Importar any Inju		> m.1/101			of Gloucest				
	- 16		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on sach l					THIRD DOLLAR	Approximate Interval Between	
-	Physician /Medical		Immediate Cause (Final disease or condition	ni setor		*			Onset and Death	
			resulting in death)	consequence of):	1	n Morria			311,0	
	Examiner		Sharecottette that economics b							
	p ##	iner								
	ecute and I-trans	Examiner	that initiated events C.	s a consequence of):						
68760,	certificate be executed nding physician and use as the burial-transit		220 10 (6) 61	ra concoquence cij.						
687	ficate phys	n/Medical	d							
X		N N	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant					23d. Date of deliv	ery	
W.	death e atter	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant		☐Ectopic pregnanc ☐ Other (specify) _			Month	Day Year	
P.0	at the by th rtache	Physicia	9 Unknown							
	The law requires that the death ate has been signed by the atter page 2 should be detached for u	by	Part II. Other significant conditions contributing to death	out not resulting in the u	underlying cause giv	ven in Part I.		co use contribute to		
oro	w require been sign	Completed					1 Tyes		bably 4 ☐ Unknown	
ec	e 2 sł	nple	<u> </u>				24a. Was an autopsy performed	24b. Were autoprior to condeath?	opsy findings available impletion of cause of	
a F	r: The						1∐ Yes 2. 🖟		2 □ No	
Vital Records,	slciar certif rector	Be	25. Was case referred to medical examiner? Hospital:		ont 317 DOA Oth	26. Place of Death (Ch				
Division or	ding Physician: The lav h. After this certificate has funeral director, page 2:	- To	27. Manner of Death 28a. Date of In	jury 28b. Time	SIL SU DOA	4 □ Nursing Home	5 ☐ Residence Describe how in		f(y)	
On	ndIng h. Afte fune	tion	1 ☑ Natural 5 ☐ Pending (Month, D 2 ☐ Accident investigation	ay Year) Injury		rk?]Yes 2 □ No				
N S	or Atteriter deat	ifica	3 Suicide 6 Could not be 28e. Place of ir	njury - At home, farm, si etc. <i>(Specify)</i>	treet, factory, office	28f. I	Location (Street City or Town, St	t and Number or Rui	al Route Number,	
	s after all Dir	Certification:	- Unionide Sulfating, 6	to. (Opcony)			only or rown, or			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certification of the funeral director, it is a completely filled in by the funeral director, it		29a. Certifier (Check only 2 Medical Examiner: On the basis	of examination and/or i						
	the hin 24 the F	Medical	one) and manner s	tated.	29c. Licens			Date signed (Month		
	Viff To	_	29b. Signature and title of certifier	Azi us			290.	tile 07	2. 2107	
			30 Name and address of a second	do oth (litera no -) IT.	Print)	21438 HOLAM ANN		(4)	10001	
			30. Name and address of person wild completed cause of	445 DEF	DUSE 176	HOLAM ANA	(HOOL)	MD 21	407	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Rujis	trar's Signature						
	Registi	rar	JUL 0 3 2007	en &	Coules					
DH	IMH 17 Rev 1/2	001								
				OP	RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otato of Many	Cei	rtificate of			g. No.	f 10 0 am 10			
ř.	Physici	an	1. Decedent's Name (First, Middle, La	st)			Day Yea	3. Time of Death					
	/Medic		PAUL I	*			14, 20						
	Examin	er	4a. Facility Name (If not institution, give Frederick Memoria			4b. City, Town, c	r Location of Deat	h	4c. County of De				
	Funeral Director		5. Social Security Number 6. S		n yrs. last birthday)	If Under 1 Year Months Days	Inder 1 Year If Under 24 Hrs. 8. Date of Birth			Birthplace (State or Foreign Country) New York			
	land t t			10d. Inside City Limits									
	ne Mary 8a-f sho ptified a	ector	Maryland Frederi	k			1XXYes 2 □ No						
920	ath with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 2402 Dominion D			21702			U.S.A.				
	be filed within 72 hours after death with the Maryland ital Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2☐ Married 3X Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 12 Yes 2 No. If Yes, Give Year or Dates:	940–1941	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2☐ X No		pecify Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc. White			
Maryland 21215-0036	hin 72 ho e. an "natu Medical	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	d of work done during most of working NOT use retired)			ss/Industry			
2	filed wil Hygien other the	Con	8		EI	ectricia	1	- (Fi - 1 4 4 1 1 1 1 4 1	Railroa	d			
land	0 = 0 5	To Be	17. Father's Name (First, Middle, Last Paul Haro	ld Gates, Sı	r.			ne <i>(First, Middle, N</i> 1erite Mag	· ·				
Mary	ind 2 shou alth and M 27 Is mai er traumai		19a. Informant's Name/Relationship (Mrs. Patricia Bro					ural Route Number, ldletown,					
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic es		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Inellioval Irolli State	20b. Place of Dispo cemetery, cree Resthaven	esition (Name of matory or other pla Memorial G	ardens, Jul	Date 20, 2007	Poc. Location - City Frederi				
21. Signature of Funera ervice Licensee MOO255 22. Nagre and Address of Facility and East Church Signature of Funera ervice Licensee MOO255 106 East Church Signature of Funera ervice Licensee							ford PA Fo	ord PA Funeral Home t., Frederick, MD 21701					
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of the condition of the condi										
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О.	uires that the de signed by the a Id be detached I	by	Tall II. Other significant conditions continuously to dealing of the analysing cause given in Fact.							o use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
al Records,	uing Physician: The law require n. After this certificate has been si funeral director, page 2 should b	Completed						24a. Was ar autops perforn 1 Yes 2	24b. Were prior death	autopsy findings available to completion of cause of ? es 2 \(\square\) No			
Viital	siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only one					
ō	Phys r this ral di	To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier	" OD DOX	4 🗆 Nursing r	lome 5 ☐ Reside		pecify)			
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Division or	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	2 Suigide 6 Could not be						reet and Number or , State)	Rural Route Number,			
	To the Hospital or A within 24 hours after To the Funeral Directional processing tilled in by	Medical (nysician: To the best of n miner: On the basis of ex and manner stated	camination and/or in								
	To the To the Comp	ž	29b. Signature and title of certifier	1)		29c. Licens		29	d. Date signed (Me	onth, Day, Year)			
			- A A	Alurh		1-	127101		July 14	,2007			
	8		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)	1271cl	41 1	21 217	0}			
ľ	。 Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	ell .		-001	,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Linda 2007 7:32P M W. July Greene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1712 Poling Avenue Fort Washington Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2🔀 F Director 53 Aug. 2, 1953 215-64-7238 Wash., DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Md. PG Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1712 Poling Avenue 20744 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Black natural The Mudical 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 5+ Teacher PG County Schools other traumatic event, 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 is marked otl Be 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Ward 2 Ruth Newsome 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1712 Poling Avenue
18d. Fort Washington, Md. 20744
20c. Location - City or Town, State 19a, Informant's Name/Relationship (Type, Print) William H. Greene Jr/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 50 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 7/12/07 Ft. Lincoln Cem. Brentwood, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Breast **Physician** -ustatic /Medical Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificete 1 ☐ Yes 2 ☒ No 1 Yes 2X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Naturaf 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 38. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reservoir Rd., Shakun Malik, 3800 NW, Washington, DC 31. Date filed (Month, Day, Year) egistrar's Signature State 2007 Registrar NEAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 08, 1:00p M 2007 Luther W. Gehring July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Federalsburg Caroline 522 Old Denton Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov. 2, 1916 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☑ M 2 □ F 90 Nov. 218-12-6153 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County Caroline Federalsburg 1 √Yes 2 No Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21632 522 Old Denton Road United States "natural", or items 23a Examiner must within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Ves 2 No If Yes, Give 42-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ul Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Parts Department Truck Dealership permit. Pages 1 and 2 should be filed wi.
Department of Health and Mental Hygien
Important: If item 27 is marked other the
any Injury or other traumatic event, the the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Gehring Martha Kruger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette C. Gehring/Spouse 522 Old Denton Road, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Hillcrest Cemetery 07/12/07 Federalsburg, MD 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee Muharl 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 8 ma-THS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or all a consequence of) Examine death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has certificate 1□ Yes 2☑No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA မ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending P safter death. Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death To the Funeral Director:

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

29b. Signature and title of certifier

Ludwig



29c. License number

29d. Date signed (Month, Day, Year)

MD

Easton.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 9. Sara Ann Heimiller July 2007 19:20 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Calvert Manor Nursing Home Rising Sun
If Under 1 Year If Under 24 Hrs. Cecil 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛪 F Director 1922 Maryland 215-12-7358 85 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral, or Itams 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23a any njury or other traumatic event, the Medical Examinat must page. 11 Squirrel Ct U.S.A. 21921 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Wildowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Secetery Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 William James Walker Lillian Creswell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra McCarthy (Daughter) 11 Squirrel Ct. Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/13/2007 Angel Hill Cemetery Havre de Grace, MD 21. Signature of Fageral Service Lie 22. Name and Address of Facilitzellman Mitchell Smith Funeral Home 123 S Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, you mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Little only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preymence Spiration **Physician** disease or condition resulting in death) 10 cent /Medical Due to (or as a consequence of): Examiner Swallowing 6 mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequed of): Completed by Physician/Medical Examiner Vascular Acciden erebral or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): P.O. Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Atrial Fibrillation 3 Probably 4 Unknown Stroke 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Depression. 2 00 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner?
1 Tyes 2 No Be 26. Place of Death | Check only one Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatrent 3 DOA 4 Jursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be 3 Sutcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospitel Certifying Physician: To the best of my knowledge, death accurred at the time, date and close, and due to the date site of a stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Way, Rising Sun, MO 21911 101 COLONIAL E. LATTIN, MN 31. Date filed (Month, Day, Year)
JUL 1 9 2007 Registrar's Signature State Registrar

Registrar

			1 - For State Registrar		State of	Marylar	-			lealth a Death		ental Hyg	jiene	15	Ī	23253
•	Physici		1. Decedent's Name (First, Middle, Lois G			Ho1d	a					2. Date of Dea Month June 29	Day		Year	3. Time of Death 7:20P. M
	/Medic Examin		4a. Facility Name (If not institution,	give st	reet and num	nber)		4b. City, Town, or Location of Death 4c. County						of Death		
			Lorien of Mt. A					1	t. A:	J				Carı	roll	
	Funeral		, , , , , , , , , , , , , , , , , , , ,	6. Sex	M 2 🛣 F		. last birthday) Yrs.	Months 1	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day	, Year)	2	Cou	place (State or Foreign
	Director		579-40-9287 Usual Residence of Decedent			74_					A	lug 21,	193	32	was	hington,DC
	how		10a. State 10b. County				ity, Town or Lo	cation								10d. Inside City Limits
	Ba-1 e	Funeral Director	Maryland Howar	d ———		Mt	. Airy									1 ☐ Yes 2 🛣 No
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۵	or Iten	Fun	1 ☐ Never Married 2 ☐ Marrie	_	Armed For 1 Tes	ces? 2 💢 No					i, Puèrto F	cify Yes or No- Rican, etc.)		Blac	k, White	, etc.
20	be filed within 72 hours after death with the Maryland Hygiene. I have they than "natural", or items 23a or 28a-f ehow do ther than "natural", or items 23a or 28a-f ehow event, the Madical Examinar must be notified at	d by	3 ₩ Widowed 4 Divorced		If Yes, Giv Year or Da	e ites:		1 L Yes	2 X 1 N0	Specify:				Specify	: W.	hite
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ק פ	illed Hygi other	Be Co	17. Father's Name (First, Middle, L	ast)			1	<u> </u>	arei	18. Mothe	er's Name	(First, Middle,				
<u> a</u>	should be nd Mental i marked o umatic eve	To B	Kenton		Roll	ison				Mar	У	Lucinda	a	I	ett	is
Maryland 21215-0036	C1 40 = 00		19a. Informant's Name/Relationsh Teresa G. Holda/					-				Route Numbe	-			ip Code)
d)	tem 27		20a. Method of Disposition		5	206.	Place of Dispo	sition (Nai	me of			ate				Town, State
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or of once.		1 ☐ Burial 2 😿 Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ⊟Re <i>ecify)</i>	moval from S	State St	cemetery, crei auffer	•		. 1	ulv 5	, 2007	Fre	ederi	ick,	MD
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n	80 5 5 8		Karulla				· · · · · · · · · · · · · · · · · · ·					l., Mt.		cy, N	4D 2	1771
	Physician		23a. Park Enter the disease, or o shock, or heart failure. List o	complic inly one	ations that ca cause on ea Pneum	ach line.	th. Do not ent	er the mod	de of dyin	g, such as	cardiac or	respiratory an	rest,			Approximate Interval Between Onset and Death Weeks
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200	tificate ig phys as the			- u												
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о П	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4□ Pregna 9□ Unkno	ant at time of		Other (sp						Moi	ntn	Day Year
J.	res that the de signed by the a be detached t		Part II. Other significant condition	ns cont	ributing to de	ath but not re	sulting in the u	nderlying o	ause give	en in Part I.		23e. Did to	bacco	use conti	ribute to	the cause of death?
Vital Records,	uires n sign lld be	d by	Cachexia, Hypo	A11	bumeni	a, Ele	ctrolyt	e Unl	balaı	nce		1 🗆 Y	es 2	□No	3 🗆 Pro	obably 4∑Unknown
<u> </u>	s been si	Completed	Depression									24a. Was a		24b. \	Nere aut	opsy findings available
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Ita	iysician: The lav ils certificate has director, page 2	Bec	25. Was case referred to medical examiner?							26. Place	of Death	Check only or	-			24.10
<u> </u>	Physic this ce al dire	은	1 ☐ Yes 2 ☐ No	Ho		•	ER/Outpatier			4 🗆 Nu						(fy) Assist
Division of	ng f	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		28a. Date o (Monti	of Injury h, Day Year)	28b. Time o Injury	f A	28c. Injun Worl	yat k? Yes 2 □		8d. Describe h	ow inju	ry occurr	ed	Living
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	al or / s after il Dire	Serti	4 Homicide	160	buildir	ng, etc. (Spec	ify)					City or Tow	n, State	э)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr	edical C	29a. Certifier 1 Certifying (Check only one)	Physi xamin	cian: To the er: On the ba and mann	isis of examin	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	d place, as th occurre	nd due to the o	ause(s)) and ma d place, a	nner as and due	stated. to the cause(s)
	within To the	Me	29b. Signature and title of certifier		1.	nn		290	c. License	e number			29d. Da	ite signed	d (Month	, Day, Year)
•			Allen	//	Cec	lleg	mp	1)54	174	9		Ju1	Ly 1	, 20	07
	O_i		30. Name and address of person v													
سنور	10		Allen Reilly,	MD		_		D-1	, Fre	ederi	ck,MD	21701				
	Sta	te	31. Date filed (Month, Day, Year)	R 20	107 32. R	sistrar's Sign	ature	book								

07-05301 Rodney D. Hanby

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Medical Examiner Rondy Dale Hamby July 10, 2007	Foreign Country) NC
The state of the s	ty of Death YY) 9. Birthplace (State or Foreign Country) NC
The state of the s	YY) 9. Birthplace (State or Foreign Country) NC
Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. June 1, 195 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Where the property is a state 10b. County 10c. City, Town or Location Where the property is a state 10b. County 10c. City, Town or Location Where the property is a state 10b. County 10c. City, Town or Location Where the property is a state 10b. County 10c. City, Town or Location Where the property is a state 10b. County 10c. City, Town or Location Where the property is a state 10c. City, Town or	Foreign Country) NC
Director 213-68-0789 1x M 2 F 51 Yrs. Months Days Hours Min. June 1,195 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Cecil Elkton 10b. Street and Number 10f. Zip Code 10g. Citizen of 10g. Citizen	Foreign Country) NC
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Fig. 10c. City, Town or Loc	oq NC
To a. State 10b. County 10c. City, Town or Location 10c. City Town or Lo	
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11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No 1 No specify: 1 No specify: 1 No specify: 1 Yes 2 X No specify:	١.
Specify Specify	ace - American Indian, Black, hite, etc.
Specify Specify	
or Dates:	
during most of working life. DO NOT use retired)	Business/Industry
2 1 2 2 Elementary/Secondary (0-12) College (1-4 or 5+)	
15. Decedent's Education (Speciny chiphreted) 16. Decedent's Education (Speciny chiphreted) 16. Decedent's Education (Speciny chiphreted) 16. Decedent's Education (Speciny chiphreted) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnar	struction me)
98 O-1	
19b. Mailing Address (Street and Number or Rural Route Number, City or T	own, State, Zip Code)
Reba G. Reeves 176 Skyview Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location 1.00 of Disposition)	
20c. Location 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location 20c. Location 3 Removal from State (Section 20c. Location 3 Removal from State (Section 3 Removal from State (Sectio	on - City or Town, State
20a. Method of Disposition 20a	on, MD
The state of the s	2
259 E. Main St. Elklon. N	
failure. List only one cause on each line.	Between Onset and
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): disease	vascular
Sequentially list conditions b.	
if any, leading to immediate Cause. Enter Underlying Cause Due to (or as a consequence of):	
(Disease or injury that initiated Due to (or as a consequence of):	
A definition of the state of th	
When the standing in death) Last Spanned	
9 1 1 1 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Month	e of delivery
So the past 12 months? Continue of the past 12 months Continu	h Day Year
23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	
O to the sport of	ontribute to the cause of death?
To Yes 2 No	3 Probably 4 ✓ Unknown
Records Seconds Seco	b. Were autopsy findings available prior to completion of cause of
performed? 1 ✓ Yes 2 No	death? 1 ✓ Yes 2 No
OC Disea of Death (Charle only one)	
Performed? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Ves 2 No 28d. Describe how injury or (Month, Day, Year) 28d. Describe how injury or Subject exposed	6 Other: Scene
C = : +1 O 1 1 Natural c p ::	to high
See. Place of Injury - At home, farm, street, factory, office building, etc. Natural 5 Pending Investigation Fnd 7/10/2007 Fnd 1:02 pm 1 1X Yes 2 No environmental telegraphic pm 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Nu.	mperature umber or Rural Route Number, City
25. Was case referred to medical examiner of Death of the street of the	
and the state of t	
육 등 욕을 🔑 👊 one) 2 🗹 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, an	nd due to the cause(s)
and manner stated. 29c. License number 29d. Date s	signed (Month, Day, Year)
	2007
O.C.M.E. July 11,	
O.C.M.E. July 11, 30. Name and address of person who completed cause of death (Item 23a)	
O.C.M.E. July 11,	

ORIGINAL

7-∪5263 1arcus A. Jacks	าก	Please Type or							ble.	
Idi ous A. daoks		1- For State	Maryland			n neaim ar If Death	nd Mental Hy		. 96	E7 0392
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	-		10010 0	- Boatin		Reg. 2. Date of Death		3. Time of Death
Medical Examir	er	Marcus A		Jackso	n			Month Duly 9, 2007)ay Year	1905 hrs
		4a. Facility Name (if not institution, give s	treet and number)			-	or Location of Death		4c. County of D	
		3449 Regency Parkway				Suitland	Transport	To Die Chill	Prince Ged	orge's
Funeral Director		5. Social Security Number 215–33–4976		e (In yrs. last 16		If Under 1 Ye Months Da		March 12	. 1991	. Birthplace (State or preign Washington
	-	Usual Residence of Decedent	2F		Yr	S.		1	,	Country) LC
any	•	10a. State 10b. County		10c. City, To	wn or Loca	tion				10d. Inside City Limits
aryland 8a-f show any at once.	ᆡ	Maryland Prince Geor	ge's	For	restvi	lle				1 Yes 2 XX No
Varyla 28a-f	Director	10e. Street and Number				10f. Zip Code		. 109	. Citizen of What	Country?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		3449 Regency Parkway					0747		USA	
th wit	Funeral	11. Marital Status 1 XX Never Married 2 Married	2. Was Decedent Armed Forces?				lispanic Origin? (Sp an, Mexican, Puerto		14. Race - A White, e	merican Indian, Black, tc.
er dea			Yes 2 Yes, Give Year	X No	1	Yes 2XX N	o enceifur	•	Specify:	Black
urs aft tural"	흿	15. Decedent's Education (Specify only	r Dates:	npleted) 16	Sa. Decede		ation (Give kind of v	vork done	6b. Kind of Busin	
72 hor "ua	ete	Elementary/Secondary (0-12)	College (1-4 or	5+)			fe. DO NOT use retir	red)	Cohoo1	
5-0036 led within 72 hou Hygiene. other than "nat	Completed	9			Stude	ent			School School	
15-00 filed wit I Hygien ed other t, the M		17. Father's Name (First, Middle, Last) Warren Orlando Jac	kson Sr.				18.Mother's Name Brenda I	(First, Middle, Ma averne Fu		
/ T = 2 = 3	To Be	19a. Informant's Name/Relationship (Type			19b. Mailir	ng Address (Stre	eet and Number or F			State Zin Code\
MD and 2 show m 27 is a au matic		Brenda L. Jackson / M		ï	3449	Regency Pa	arkway Fore	stville, M	aryland 2	0747
imore, MD 2 Pages 1 and 2 shoul ment of Health and h tant: If item 27 is n or other traumatic		20a. Method of Disposition		20b. Plac		sition (Name of co	emetery,	Date	20c. Location - Ci	ty or Town, State
Pages ent of not he r other		1 XX Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from St	Resur	rection	n Cemetery	φ7/16	/2007	Clinton,	Maryland
Baltimore, permit. Pages 1 and Department of Heal Important: If iten	Ì	21. Signature of Funeral Service Lice se	e				ss of Facility 😘			
			ann				Hill Road O		-	
Physician /Medical		23a. Part I. Enter the disease or complicate failure. List only one cause on each	line.				10.75	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
xaminer	İ		Cardiac an		assoc	iated with	obesity			Death
		Sequentially list conditions, b	e to (or as a cons	equence or).						
	ner		e to (or as a cons	equence of):						
0	Examiner	(Disease or injury that initiated C	e to (or as a cons	equence of):						_
		d								
be execute	Physician/Medical	X UNPENDED	#23a,27.p	erME.g87	1. 9/1	1/07 TT				
Box 68760, e death certificate be the attending physic of for use as the but	Ne l	IF FEMALE; 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregnan	тсу				23d. Date of de	
K 68	ciar	past 12 months?	Live birth Pregnant at	time of death		etal death 3 Other (Specify)	Ectopic pregna	incy	Month	Day Year
BO) e death the att	hysi	1 Yes 2 No 9 Unknown	9 Unknown			74101 (-)				
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physicianeral director, page 2 should be detached for use as the bur	by P	Part II. Other significant conditions co	ontributing to deat	h but not resu	Iting in the	underlying cause	given in Part I.		_	te to the cause of death?
S, F quires an sign	be				···			1 Yes		Probably 4 Unknown
ord aw rec as bee 2 shou	Completed							24a. Was an autopsy perform	prio	re autopsy findings available r to completion of cause of
Rec The 1 icate Page	है							11 ✔ Yes 2		Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Be C	25. Was case referred to medical examiner?	pital:				Other Nursin			
Physicar this	유.	1 ✓ Yes 2 No 27. Manner of Death	· I _ Inpatie		∛Outpatier 3b. Time of		jury at Work?	g Home 5 R	esidence 6 🗸	Other: Scene
nding nding th.	<u>.</u>	1 X Natural 5 Pending	28a. Date of Inju (Month, Day,)	'ear)			Yes 2 No	200, 2000, 100 110		
r Atte r Atte ter des irecto	g	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of In	ijury - At home	e, farm, str	eet, factory, office	building, etc.	28f. Location (Str	eet and Number of	or Rural Route Number, City
urs aff	Certification:	3 Suicide 6 Could not be determined	(Specify)					or Town, Sta	te)	
Hosp 24 ho Fune		29a. Certifier 1 Certifying Physician								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical		n the basis of exa nd manner stated.	mination and/	or investiga					
	Σ	29b. Signature and title of certifier	N.				nse number			(Month, Day, Year)
		high	i, in	P		0.0	C.M.E.		July 10, 2007	
		 Name and address of person who cor Ling Li, MD Assistant Med 		,	,	et, Baltimore	MD 21201			
Sta	fe	31. Date filed (Month, Day, Year)		r's Signature	STILL OUT	2. a	, 1410 2 1201			

OCME

			State of Maryland / Dep		lental Hygier	ne
			- negistral	ertificate of Death	Reg. N	
F	Physici /Medic		1. Decedent's Name (First, Middle, Last) RUBY VAUGHAN KETCHEL		JULY 15	3. Time of Death 3. 2007 1:20A M
N. S.	Examir		4a. Facility Name (If not institution, give street and number) 1 4 0 7 REDWOOD CIRCLE	4b. City, Town, or Location of Death LA PLATA		4c. County of Death CHARLES
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday $245-20-4564^{1}$ $45-20-4564^{1}$ $45-20-4564^{1}$	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 1 1 - 1 4 - 1	9. Birthplace (State or Foreign Country) 9. 1. Significant State of Foreign State of Forei
- 5	- heat		Usual Residence of Decedent		1 1 1 1 1 1 1	720 1100
	Maryland f show ied at	tor	10a. State 10b. County 10c. City, Town or L	LA PLATA		10d. Inside City Limits 1 X Yes 2 ☐ No
	vith the	Director	10e. Street and Number 1407 REDWOOD CIRCLE	10f. Zip Code 20646	_	Citizen of What Country?
(O	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
-003 -003	thours a atural", c	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	1 ☐ Yes 2 ☒ No Specify: edent's Usual Occupation	16b.	Specify: WHITE Kind of Business/Industry
1215	within 72 ene. than "na ne Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th	e kind of work done during most of worki DO NOT use retired) HOMEMAKER		WN HOME
Maryland 21215-0036	2 should be filed and Mental Hygic is marked other aumatic event, the	Be	17. Father's Name (First, Middle, Last) JESSE VAUGHAN	18. Mother's Name	(First, Middle, Maid	en Surname)
7	2 should and Men is marke	욘		ling Address (Street and Number or Rura		v or Town, State, Zip Code)
, ⊠a	1 and 2 s Health ar em 27 is		1 1 1 1	7 REDWOOD CIRCLE		•
Baltimore,	Pages 1 and the subsection of		1 TRurial 2 XCremation 3 LiBernoval from State 1	position (Name of ematory or other place) AN CREMATORY 7-2		Location - City or Town, State
Balti	permit. Departri Importa any inju		21. Signature of Juneral Service Licensee M00479	22. Name and Address of Facility RAYMOND FUNERAL LA PLATA, MD. 206	SERVICE	, P.A.
		377	23a. Part1. Enter the disease, or complicing that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	OTIC CARDIOVA		Onset and Death
ſ	/Medical Examiner		Due to (or as a consequence of):	,		
1 k	led Issit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiate course).			
υ√ 0	cate be executed ohysician and the burial-transit		that initiated events resulting in death) Last			
38760,	icate be	dical	d			-
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P	uires that signed by d be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,	ne law req has beer ge 2 shou	Completed	DIABETES		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ţ	an: Ti tificate tor, pa	Be Co	25. Was case referred to medical	26. Place of Deat	performed 1 Yes 2 A n (Check only one)	No 1 ☐ Yes 2 ☐ No
	nysici nis cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other:	. 1	6 ☐Other (Specify)
o uc	ling Pl After th 'uneral		27. Manner of Death 28a. Date of Injury 28b. Time Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	njury occurred
Division or	Hospital or Attending I 24 hours after death, Funeral Director; After stely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Co	29a. Certifier (Check only one) 1			
	To the H within 24 To the Fl complete	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			· WALL	1)12906		7/16/07
	u		30. Name and address of person who completed cause of death (Item 23a) (Type	70 old Live Cente	er wal	, md. 20602
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 1 9 2007	rde		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CLARENCE ADDISON LOUK JULY 16,2007 :00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplac Country | DEC - 10, 1923 | W • VA • 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days 234-32-4794 1X M 2 F 83 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD. CHARLES LA PLATA 1 X Yes 2 ☐ No notified Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o **#1 MAGNOLIA DRIVE** 20646 U.S.A. Items 23a Pages 1 and 2 should be filed within 72 hours after death unent of Health and Mental Hygiene. by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

XXYes 2 □ NoARMY
IIYes, Give WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Year or Dates: WWII Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NAVAL ORIDNANCE r than College (1-4or 5+) Elementary/Secondary (0-12) U.S.GOVT. PROPELLENT SPECIALIST 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GAY LOUK COMILLA LOUK ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Item 27 is or other tra HELEN LOUK-SPOUSE P.O.BOX 1495 LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place)
3 □Removal from State TRINITY MEM.GARDENS 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation permit. Page Department of Important: If any Injury or once. 7-20-07 WALDORF, MD. 4 Donation 5 Dother (Specify) M00479 21. Signature of Funeral Service Licensee 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy perform 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manner of Deat 1 Natural 2 Accident 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

P.O. Box 68760, Division or Vital Records, within 24 hours a completely

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

9 2007

Id LineCtr #302 Wa

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 🗸 U U / 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** М A. 11, Kennette July 2007 0402 Laird /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 8207 Anaio Court Clinton Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month. Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Director 31 4,1976 Wash.,DC 212-13-4209 March Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Itema 23e or 28e-f show ury or other treumatic event, the Medical Exprinter must be notified as 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No Director MD. PG Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8207 Anaio Court 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Dept. of Justice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth Karen King Wade 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8207 Anaio Court
Clinton, Maryland

20b. Place of Disposition (Name of cemetery, crematory or other place) Joseph Laird/husband 20735 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cem. 7/18/07 Cheltenham, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat **Physician** Rencardial effusion and progressive lung disease disease or condition resulting in death) /Medical Examiner 11/2 years Metastatic Breast Councer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) by the a 9□ Unknown ል certificate has been signed l irector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: this certific ral director, Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 【▼ Residence 6 ☐ Other (Specify) ၀ 1 ☐ Yes 2X No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD Kalt D65643 07/13/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 Rockledge Drive, SuiteSOG, Bethesda, MD 20817 B Rehecca D. Kaltman, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature 1 ... 18 8 State A TOTAL Registrar

07-05295 Alicia D Lee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day July 10, 2007 0735 hrs Medical Examiner <u> Alicia</u> Dawn 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Wicomico 1313 Old Ocean City Road Salisbury 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. **Funeral** oreign Months Davs Hours ^{reign} West C**Wit**rainia Director 233-29-9648 21 11/20/1985 1 M 2 X F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County X Yes 2 No 28a-f show Wicomico Salisbury Maryland narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1313 Old Ocean city Road 21804 USA Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No Baltimore, MD 21215-0036
permit. Pages i and 2 should be filed within 72 hours after i
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", o
injury or other traumatic event, the Medical Examiner in Yes, Give Year Yes 2 X No specify: Specify: white Widowed Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Student Education 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Phillip Alan Lee æ Rhondalyn Gay Branham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evangelist Phillip Alan Lee/father 1313 Old Ocean City Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Wicomico Memorial 1 X Burial 2 Cremation 3 Removal from State 7/16/07 Salisbury, MD Donation 5 Other Specify: Park 21 Signature of Funeral Service Licensee ²²Holloway Funeral Home Professional Association 17 501 Snow Hill Rd., Salisbury, MD 21804 Composit 23a. Part I. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. //wedical Death a Sepsis Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical X UNPENDED attending physician for use as the burial A#ENDED, 27, perME, 8870, 8/9/07 TT The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 ✓ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ Yes 2 No 3 Probably 4 ✔ Unknown Bullemia Completed icate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 After this certificate funeral director, page No 1 🗸 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other: ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient ۵ 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 11, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State 6 200 Registra

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Registrar

	•	For State Registrar			,	Cei	tificate of	Death	,	Reg. No.	2007	23260
		1. Decedent's Name (First, A	fiddle, Last,						2. Date of De Month	eath Day	Year	3. Time of Death
Physicia /Medic		Jam	es E.	Laws,	Jr.				July	1	2007	9:23A M
Examin	114	4a. Facility Name (If not insti-	ution, give	street and nu	mber)		4b. City, Town, or	r Location of Death		4c. (County of Death	
	4	Southern					If I Index 1 Vons	Clinton	To Bets of Bi	45		George's
Funeral		5. Social Security Number	6. Se	(]M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bil (Month, Da	ay, Year)	Cou	place (State or Foreign intry)
Director		577-54-8710 Usual Residence of Deceder	t		67				Oct. 1	0, 15	9391 Wa	sh., DC
/land ow at		10a. State 10b. Co			10c. Ci	y, Town or Lo	cation					10d. Inside City Limits
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2 sho and I is ma		19a. Informant's Name/Rela	tionship (T)	rpe. Print)		19b. Mailir	ng Address (Street	and Number or Rui	ral Route Numb	ber, City or	Town, State, Zi	ip Code)
and ealth m 27		Diane M.	Laws/	Wife	l not-	701	1 Tarquir	Ave., T	emple H	ills,	MD 20	748
ges 1 t of H If itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema	tion 3 🗆 F	Removal from	State	cemetery, cirei	natorý or other plad	ce)		20c. Loc		<i>'</i>
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Se	vice Licens	ee	H	- 2		ss of Facility S Benning				
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Physician /Medical		disease or or ndition resulting in death)	-	a. Due to	(or as a consec	CA CA	CANC	X / ·			-	
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	edical	(Check only 2 ☐ Me one)	dical Exam		basis of examin nner stated.	ation and/or ir	ivestigation, in my	opinion, death occu	irred at the time	e, date and	place, and due	to the cause(s)
To the within To the comp	Me	29b. Signature and title of c	ertifier	70			29c. Licens	se number	1	29d. Dat	e signed (Month	n, Day, Year)
	30. Name and address research to complete d cause of death (Item 23a) (Type, Print) 28 Southern Ave. SE Washington									2007		
-(12)		30. Name and address of m	VEOD WOO	om let d cau	ise of death (Ite	m 23a) (Type,	1328 S	othern	Ave. Si	EL	URShin	ston DC
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Registi		JUL 0 5 200		Brew	Registrar's Sign	outs						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JULY 1.3 Day 10:00 AM LESTER W 2007 MILLER /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month Day, Year) Jul 31, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country). **Funeral X**□ M 2□ F Months Director 214-07-5946 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the M. dical Examiner must be notified at Myersville Frederick MD 1 ☐ Yes 🎾 ☐ No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or USA 21773 4531 Fisher Hollow Road . Was Decedent Ever in U.S. Armed Forces? 1 Yes No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 or, 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, the Magnes." Elementary/Secondary (0-12) College (1-4or 5+) Retired Carpenter RAAB Contracting Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude (Murphy) Miller John W. Miller P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zio Code) 4531 Fisher Hollow Road Myersville MD 21773 19a. Informant's Name/Relationship (Type. Print) Maryland Miller wife 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State scarpelli Funeral Home, P.A. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/16/2007 MD Cresaptown 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Nam Starbeins Fufier H Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. proximate Interval Between Onset and Death Immediate Cause (Final disea e or condition resulting in death) **Physician** ettwich EYMY /Medical u to (or as a consequence of) Examiner concur Sequentially list conduons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy perform this certificate To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 ☐ Pending investigation TULY 11 2007 While 1 ☐ Yes 2 X No Accident Walking 6 Could not be 28e. Place injury - At hom building, etc. (Specify) 3□ Suicide At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 453| FISHER HOLLOW ROAD, MYER 4 Homicide HOME Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending Physician; The law requires that the death certificate be executed To the rock within 24 hours after deam.

To the Funeral Director: Aft to the funeral Director.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) th 31. Date filed (Month, Day, Year) ST. m. D FREDERICK mo 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jul 15, 2007 Physician 8:25AM M Markel Jr. Allen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Nancy Road Allegany Oldtown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 13, 1922 Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) Social Security Number 6. Sex 1 M 2 □ F 217-14-0734 84

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner Division or Vital Records, P.O. Box 68760,

Funeral

Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Be Completed by Funeral Director	P.O. B				10, 0000	21555		USA					
Ē	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H	lispanic Origin? (Sp.	in? (Specify Yes or No- Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.						
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	20a. Method of Dis			20b. Place of	f Disposition (Name of ry, crematory or other pla	(ce)	Date 2	20c. Location - City or	r Town, State				
	_	☐Cremation 3 ☐ 5 ☐ Other (Specif]Removal from State y)		Memorial Park		7/18/2007	Cumberla	ind MD				
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that initiated events c.													
Exa	resulting in death) Last C. Due to (or as a consequence of):												
ca	d												
<u>e</u>													
2	IF FEMALE: 23b. Was decede	nt pregnant	nant 23c. If yes, outcome pf pregnancy 23d. Date of de 1 □Live birth 2 □ Fetal death 3 □Ectopic pregnancy										
<u> </u>	in the past 12 1 ☐ Yes 2	in the past 12 months? 1 Yes 2 No Aprenant at time of death 5 Other (specify) Month											
hys	9 ☐ Unknow												
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
Completed by	DIF	DIABETES, HYPERTENTION 10/908 2 NO 3 1											
<u>e</u>			,				24a. Was ar	as an 24b. Were autopsy findings a					
Ē							autops perforr	ormed? death?					
_	25. Was case refe	erred to medical				26. Place of Deat	th (Check only on						
o Be	examiner?		Hospital: 1 Inpatie	nt 2∏ER/O	utpatient 3 DOA Ot		ence 6 □Other (Sp.	ecify)					
0	27. Manner of Dea		28a. Date of Inju	ry 28b.	Time of 28c. Inju		be how injury occurred						
<u>=</u>	1	5 Pending investigation	(Month, Day	/ Year)		rk?]Yes 2 □No							
Tica	3 ☐ Suicide	6 Could not b	Zoe. Flace of Inju	ury - At home, fa	arm, street, factory, office		28f. Location (St	reet and Number or F	Rural Route Number,				
erti	4 Homicide	dotominod	building, etc	с. (Ѕреспу)			City or Town	, State)					
<u>a</u>	29a. Certifier				e, death occurred at the								
Medical Certification:	(Check only one)	2 ☐ Medical Exa	miner: On the basis of and manner sta		nd/or investigation, in my	opinion, death occu	rred at the time, d	ate and place, and du	ue to the cause(s)				
ž	29b. Signature an	d title of certifier		19/3	29c. Licen	se number	2	9d. Date signed (Mor	nth, Day, Year)				
	1	->7	moh	lan	2 DC	0540	104	7/16,	17				
	30. Name and add	dress of person who	completed cause of d	eath (Item 23a)	(Type, Print)	\ \ \ \ \	, ,	111	-				
	Shi	r Kh	anna	133	1. F 1 lat	ional Hi	Merchel	Lavaler	MD 2150 2				
е	31. Date filed (Mo	nth Pay Year 17	32. Registra	ar's a gnature	arei .		1. 2						
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5 Sta Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11, 2007 JULY 550 M JANICE GAYNELL MEUSHAW 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MONT. WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-29-1944 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Days Hours Min 1 🗆 M WASH.D.C. 212-46-3360 64 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? APT#732 20782 U.S.A. 3601 GALLANTIN ST. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married ♣☐ Married 1 ☐ Yes 2√2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 2MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN LILLIAN MURPHY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45260 ST.GEORGES AVE. PINEY POINT, MD. MARY L.LOKEY-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City 2r0 dorn Shate 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ; 4 Donation 5 Other (Specify) METROPOLITAN CREMATORY 7-16-07 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) en while Due to (or as a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) chronic IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD.

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or edical Examiner must be

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permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr.

Funeral Director

Completed by

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death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

requires that the death certificate be executed burial-trar physician the burial attending p for use as P.0. Division or Vital Records,

page 2 s certificate has this death.

Physician/Medical Completed Be Certification: To

Examiner

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical

State Registrar 24a. Was an autopsy performed 2

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28a 28b. Time of 28c. Injury at 28d. Describe how injury occurred Injury 1 Yes 2 No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

CANROLL AVE. ma 600

31. Date filed (Month, Day, Year) 1 9 2007

29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

2 No

5 Pending investigation

6 Could not be

Registrar's Signature

the

			For State	State	of Marylar		rtment of F				_	7°% 2009	0.000
			Registrar 1. Decedent's Name (First, Middle	(a Last)		Cei	illicate of	Death		2. Date of De	Reg. No	» CUU /	3. Time of Death
П	Physicia	an		· · · · · · · · · · · · · · · · · · ·	77	26	•			Month	Da		
à	/Medic				Trevor	Mona		-1	of D4h	July	2,	2007	3:45 P M
	Examin	er	4a. Facility Name (If not institution	, ,	umber)		4b. City, Town, o		of Death		40	, , , , , , , , , , , , , , , , , , , ,	
			15404 Comus		7 4 //	14 h:-4h-d)	If Under 1 Year		24 Hrs	O. Data of Bird	Jan 1	Montgome	
Zi.	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	Yrs.	Months Days	Hours	Min.	8. Date of Birl (Month, Da	y, Year,) Cou	place (State or Foreign intry)
	Director		216-08-3924 Usual Residence of Decedent		3	7]	Dec. 21	., 1	969 Mary	land
	and w		10a. State 10b. County	,	10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	laryli sho sd at	'n											1 □Yes 2 No
	n the Marylan r 28a-f show notified at	Director	Maryland Montgo	mery	Воу	ds	T. 0. 1				40- 0		
	vith t	Ë	10e. Street and Number				10f. Zip Code				-	tizen of What Cou	muy?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	ra	15404 Comus Roa				20841				USA		
	r de tems	Funeral	11. Marital Status	Armed F		l.S. 13. V	Vas Decedent of F f Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Spe n, Puerto	cify Yes or No Rican, etc.)	-	 Race - Ameri Black, White 	
92	or i		1 XNever Married 2 Mar	If Yes. G	2 📉 No Sive		I□Yes 2X No	Specify:				Specify: Whi	.
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2	ed w ygier ier th	Completed			2	Stock	er	T				cery Sto	ore
pu	a a a	Be	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle,	Maidei	n Surname)	
Maryland	should be and Mental simarked o	2	John Michael Mc	nard				Mari]	lyn Y	vonne '	Wind	lsor	
a	es 1 and 2 should to f Health and Ment f item 27 is marked r other traumatic e		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	g Address (Street	and Numbe	er or Rura	al Route Numb	er, City	or Town, State, Zi	ip Code)
	and ealth n 27 ner tr	9	John Monard, fa	ther			4 Comus 1	Road,	Boyd	ls, mar	y1ar	nd 20841	
Sre	es 1 of He ritem		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Domeyal from		Place of Disport Cemetery, cren	sition (Name of natory or other pla	ce)	D	Date	20c. L	ocation - City or T	own, State
Ĕ		li b	4 Donation 5 Other (5			rksbur	g Method:	ist Ċe	em. 7	7/7/200	7 C1	Larksburg	g, Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Juneral Skrvice	Lidensee									uneral Home
m	Deg	0 0	- Lau de	Der	8-	2	6401 Rid	ge Roa	ad, I)amascu	s, M	Maryland	20872
	1.		23a. Part1. File the disease, o shock, or heart failure. List	r complications that	eaused the deal	th. Do not ente	er the mode of dyi	ng, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between
	6 11-1	W B	shock, or heart failure. List Immediate Couse Final					i i					Onset and Death
	Physician /Medical		disease or condition resulting in death)				nshot Wa	brund					
	Examiner			Due to	o (or as a consec	quence or):							
B		-	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying	b. Due to	o (or as a consec	ruence of):							
	ed sit	in	Cause (Disease or injury	<	0 (0. 40 4 00.100	1001100 01/1							
	and I-trar	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec	nuence of):							
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Вох	death certifi e attending d for use as	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf pregn birth 2 ☐ Feta	al death 3 ☐	Ectopic pregnanc	у			İ	23d. Date of deliver Month	very Day Year
	0 0	sic	1 ☐ Yes 2 ☐ No	4∐Preg 9□Unk	gnant at time of a	death 5∟	Other (specify) _						24,
о. О	The law requires that the d te has been signed by the tage 2 should be detached	Physician/Me	9 Unknown							00. 0111			
'n	es th gnec be de	by	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the ur	nderlying cause giv	ven in Part I	l.			/	the cause of death?
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ř	The I	Completed								autoj perfo 1⊡ Yes	ormed 2 M N	death?	ompletion of cause of 2 ☐ No
Vital Records,			25. Was case referred to medica	al				26. Place	e of Death	Check only o		0 10163	2 140
>	/sici	To Be	exapliner? 1 ☑ Yes 2 ☐ No	Hospital: 1	Inpatient 2] ER/Outpatien	t 3 DOA Oth	201:				6 □Other (Spec	rify)
ō	y Physical controls		27. Manner of Death	28a. Dat	e of Injury	28b. Time of				28d. Describe			-
0	th. th. the the	ţi	1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi	ilgi	onth, Day Year)	Injury Found 1547		rk?]Yes 2" <mark>∏</mark>	No	Sub	jed	t shot s	elf
Division or	Atter dea sctor	fica	3 Suicide 6 ☐ Could	not be 28e. Place	ce of injury - At h	orne, farm, str	eet, factory, office	•	:	28f. Location (Street a	nd Number or Ru	ral Route Number,
á	after after Dire	Certification:	4 ☐ Homicide determ	Buil	Iding, etc. (Speci	me			1	City or Tol		Rd Clant	cobuy, MD
	spita ours ours reral		29a. Certifier 1 ☐ Çertifyi	ng Physician: To the	he best of my kn	owledge, deatl	n occurred at the ti	ime, date ar	nd place,	and due to the	cause(s) and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	(Check only 2 Medical one)	I Examiner: On the and ma	basis of examination	ation and/or in	vestigation, in my	opinion, dea	ath occurr	red at the time,	date ar	nd place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifie	er .			29c. Licens	se number			29d. Da	ate signed (Month	, Day, Year)
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•	10			0 11 = (1		- 00s\ /T	Drint\				۵۷	14 3 1 20	
	4		30. Name and address of person	. Vincent	1 5	11.1	Penn Str	eet	Parl	timore.	MD	21201	
	- 04-		31. Date filed (Month, Day, Year) 32.	Registrar's Sign	ature _	Tennon	1					
13.	Sta Registi		JAL 0	6 2007	Marie	15 A	porte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State		State of Ma	aryland		rtmen tificate				1ental Hy	/giene			
	-	- 1	Registrar 1. Decedent's Nam	ne (First, Middle, La	st)		Cei	lilicati	OIL			2. Date of De	Reg. No.	200	17	3. Time of Death
	Physicia		_	oren H.	,	n						Month Ju1y	Day 4 ,	200	ear 7	5:24 P M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City,	Town, or	Location	of Death	oury		County of I		3.24 1
	Video			Kelbaugh				Thu If Under	rmor	nt If Under	Od Uro	I a a		reder		
	Funeral Director		5. Social Security 1 219–46–35		iox 7. Ag IXIM 2□F	62	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi	ⁿⁿ 944		Count	*/
1	o		Usual Residence o											Ma	ryl	
	arylar show	-	10a. State	10b. County Frederi	o.lr		, Town or Loc								10	0d. Inside City Limits 1 ☐ Yes 2 📉 No
	the M 28a-f notifie	ecto	Maryland 10e. Street and Nu		.ck	1	hurmon	10f, Zip	Code				10a Citi	zen of Wha	it Count	
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	ems 2	Funeral Directo	11. Marital Status	IDaugh Ro	12. Was Decedent Armed Forces?	Ever in U.S	S. 13. V	Vas Deced			igin? (Sp	ecify Yes or No Rican, etc.)		14. Race - A		
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2	should nd Me mark matic	ဥ	Wilbur 19a. Informant's N	lame/Relationship (Martin Type. Print)		19b. Mailin	a Address	(Street a		oe er or Rur	Me al Route Numl	eyers ber. City o	·	ate. Zip	Code)
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ore,	es 1 a of Hei		20a. Method of Dis	•	Removal from State		lace of Disposemetery, cren	sition (Nan	ne of ther place	e)	1	Date	20c. Lo	ocation - Cit	y or To	wn, State
ашшо	. Pag tment tant: I jury o			5 Other (Specif			Ridge				7/9/2					21788
מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural!" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F	uneral Service Licer	TSEE .							auffer Thurm				-
	NAME OF TAXABLE PARTY.		23a, Part1. Enter	the disease, or on	plications that caused e cause on each li	d the death								ria Z.	1700	Approximate
	Physician		Immediate Cause	(Final	e cause on each li					-						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	•	a. Due to (or as	a chisequ	ence of):	7	_	-	/ (eil e		4	-	2 11-
	Examiner	L	Sequentially list of	onditions,	b. ~ ×	6	7310		m	911	C	1110	> 1	0.1	5	
	ted nsit	Examiner	cause. Enter Und Cause (Disease of	erlying r injury	Due to (or as	.a.ecnsequ	ience of):								24111	
,	execu n and ial-trai	Exar	that initiated event resulting in death)	S	Due to (or as	a consequ	ence of):									
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_	certifica nding ph use as th	Med	IF FEMALE:													
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j.	the de	ıysic	1 ☐ Yes 2 9 ☐ Unknow		4□Pregnant a 9□Unknown	it time of de	eam 5L	Other (sp	ecity)							
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ecords	w require been sig should b											1 🕞	¥es 2	□ No 3[] Prob	ably 4 Unknown
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SION	endin ath. or; Aff he fur	Certification:	1 Natural 2 Accident	5 Pending investigation	n	iy rear)	Injury	М		Yes 2	No					
Ž	or Att fter de Sirecte in by t	rtific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe. Flace of Inj	iury - At ho tc. <i>(Specify</i>	me, farm, stre	eet, factory	, office			28f. Location Cify or To			or Rurai	Route Number,
7	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier	1 Certifylna Pi	nysician: To the best	of my know	wledge, death	occurred	at the tim	ne, date a	nd place	and due to the	e cause(s)	and mann	er as st	ated.
	e Hos 124 h le Fur sletely	Medical	(Check only one)		miner: On the basis of and manner st	of examinat										
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0	1/11		30. Name and add		completed cause of c		23a) (Type, I	Print)			-5	54		_	2	7007
	Sta	ite	31. Date filed (Mo	nth, Day, Year)	32. Rest	rar's Signat	ture	hack	•			26			4-3	1 100
	Registr			1111 06	2007	ans.	D A	1								

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3^{Dey} July Vear **Physician** DHIRLEY 9:25 AM 2007 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Frederick Braddock Heights Vindobona Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 ☐XF Yrs. January 31, 1922 Maryland Director 218-12-1868 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Dapartment of Haaith and Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 ☐ Yes 2 💆 No Funeral Director Braddock Heights Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number USA 21755 4410 Holter Court 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Merried White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seafood Company 12 Administrative Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Lest) Be Eva Hayman ည Gordon E. Milbourne 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sband) 4410 Holter Court - Braddock Heights, ND 21755

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State William B. Maddox, Jr. (Husband) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/7/2007 Crisfield, Maryland Asbury Cemetery 21. Signeture of Funeral Service Licer 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Mary Both Brown 306 W. Main Street - Crisfield, MD 21817 Mary 23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 5 DAYS Immediate Ceuse (Final disease or condition resulting in death) /Medical PNEUWONIA Examiner Due to (or es a consequence of): ACCIDENT CEREBROVASCULAR Physician/Medical Examine Hospital or Attending Physician: The law requires that the death carlificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulting in death). Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? DISEASE 1 Yes 2 No 3 Probably 4 Unknown HELLEIMER'S Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 1 Naturel 5 Pending 2 🗆 No 1 Yes death. investigation 2 ☐ Accident Director; A 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide efter To the Hospital or within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature end title of certifier 020488 7/3/0 MIDDLETOWN, MD. ZI769

Registrar **DHMH 16 Rev 6/95**

State

rer's Signature

40 BOX 20

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

200

AMES L.

31. Dete filed (Month,

ROESSLER MD

32. Red

Age (In yrs. last birthday, 74 Yrs.

10c. City, Town or Location

Fort Washington

Certificate of Death

Hyattsville

Months

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

2. Date of Death Month TUNG

Utens BURY Rd Hyatteville My 20181

8. Date of Birth
(Month, Day, Year)
Jan. 17, 1933

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

5. Social Security Numbe 048-26-8041

10e. Street and Number

11. Marital Status

10a. State

MD

Direct

Funeral

2

Completed

Be

Usual Residence of Decedent

212 Aragona Drive

1 Never Married 2 Married

3 ☐ Widowed 4 ☑ Divorced

Elementary/Secondary (0-12)

Ollie Deloatch

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Thelma Louise Miller

10b. County

Facility Name (If not institution, give street and number)
Saint Thomas More Nursing Home

Prince Georges

15. Decedent's Education (Specify only highest grade completed)

1 □ M 2X F

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:

College (1-4or 5+)

Brenton Miller - son 212 Aragona Drive, Fort Washin 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Resurrection Cemetery 7-6-07 4 ☐ Donation 22. Name and Address of Facility Bell & John 21. Sign ure of Funeral Service 6503 Old Branch Ave., Templ 23 Pa 11. Enter the disease, of shick, or heart failure. Lis o/cor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrests only one cause on each line. Im neclate Cause (Final di esse or condition AVIEW WS cherot di be se or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob þ 1 ☐ Ye certificate has been si rector, page 2 should Be Completed 24a. Was ar autops perforn 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Reside 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe ha 28c. Injury at Work? After 5 Pending investigation 1 Natural Injury thours after death.

uneral Director; Afely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

own or Location			10d. Inside City Limits
Washington			1 ☐ Yes 2/CXNo
10f. Zip Code 20744		itizen of What Co	ountry?
13. Was Decedent of Hispanic Origin? (Specil If Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
1 ☐ Yes XX No Specify:		Specify: B1a	ack
 Ba. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 	16b.	Kind of Business	/Industry
icensed Practical Nurse	He	althcar	2
18. Mother's Name (#			
Elsie Lee	Barham		
19b. Mailing Address <i>(Street and Number or Rural F</i> 212 Aragona Drive, Fort			
e of Disposition (Name of Dat etery, crematory or other place)	e 20c.	Location - City or	Town, State
rrection Cemetery 7-6-0	7 c1	inton, N	4D
22. Name and Address of Facility Be11			
6503 Old Branch Ave.			
denotic Candiovasco	elar Di	Sease	Interval Between Onset and Death Y Rais
ice of):			
y sath 3⊟Ectopic pregnancy h 5⊡ Other (s <i>pecify</i>)		23d. Date of de Month	livery Day Year
ng in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
lyss .	1 ☐ Yes	2□No 3□P	robably 4 donknown
CN	24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of
26. Place of Death (
Outpatient 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Spe	cify)
Bb. Time of 28c Injury at 28c	d Describe how in	ury occurred	

650 AM

9. Birthplace (State or Foreign Country) Virginia

2007

Prince Georges

c. County of Death

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 5 2007

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 07 2:20 A M 26 06 Dorothy F. Manzolillo 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sykesville Carroll Brinton Woods Nursing Center If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 💢 F 86 251-12-9430 Mar. 5, 1921 S.C Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d Inside City Limits MD Howard Mount Airy 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 737 West Watersville Road 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Specify 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ferguson Ford Margaret Glass 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 737 West Watersville Rd. Mount Airy, MD 21771 Charles Michael Manzolillo/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 25, 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Arlington National Arlington, VA 4 □ Donation 5 □ Other (Specify) 2007 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy. Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) arestive Due to (or as a correquence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a nonsequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Rolling 1 Tes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ₩0 24a. Was an 1□ Yes 2 1 No 1[6 ☐Other (Specify) v occurred

law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician use as t for the þ signed b page 2 should certificate has

Physician:

Hospital or Attending

funeral director.

completely

After this

death.

24 hours after death Funeral Director: filled in by the

within 2

Physician

/Medical

Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical Examiner

Be Completed by

Certification: To

Medical

29a. Certifier

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Experience.

3altimore, Maryland 21215-0036

s case referred to medical				26. Place of Dea	ath (Check only one)
aminer?]Yes 2∐No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient	3 DOA	Other: 4 Nursing H	Iome 5 Residence
nner of Death	28a. Date of Injury	28b. Time of	28c.	Injury at	28d. Describe how injur

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) JUL 0 3 2007

il 4160

			For State	State	of Maryl	•	artment of H				0	007	22260
			Registrar 1. Decedent's Name (First, Middle	- / oat)		Cei	lilicale of	Deain		2. Date of Dea	Reg. No.	007	3. Time of Death
	Physicia	an								Month	0,20	O7	4:56p M
	/Medic		Ruby Jane N 4a. Facility Name (If not institution		umher)		4b. City, Town, o	or Location o		Julie 3		unty of Death	
	Examin	er	Union Hospi	-			Elkton					Ceci	1
. ,	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year		24 Hrs. (8. Date of Birtl (Month, Day	(Vear)	I Cou	place (State or Foreign ntry)
	Director		212-48-9591	1 □ M 2 🙀 F	58	Yrs.	Months Days	Hours	Se Se	ptemb	er 2	,1948	WV
	pu >		Usual Residence of Decedent 10a. State 10b. County		100	. City, Town or Lo	ncation						10d. Inside City Limits
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	the N 28a-1 notifi	rect	10e. Street and Number			DIROO	10f. Zip Code				10g. Citizer	of What Cou	intry?
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	death ms 2 r mus	Funeral Director	11. Marital Status		cedent Ever	in U.S. 13.	Was Decedent of H		igin? (Spec	cify Yes or No-		Race - Ameri Black, White	can Indian,
9	after or ite mine		1 ☐ Never Married 2 ☐ Marr	ried 1 ☐ Yes	No No		1 ☐ Yes 2 X No			ilcan, etc.)		pecify:	White
3	nours ural", I Exa	d by	3 Widowed 4 Divorced	Year or	Dates:	1							
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7	withir ene. than	ᇤ	Elementary/Secondary (0-12) 1 2	College	(1-4or 5+)		chine O				Ne	wspap	er
א כ	Hygi Hygi other ent, t	Be Co	17. Father's Name (First, Middle,	Last)		1100				(First, Middle,	Maiden Su	rname)	
ō	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ТоВ	Jennings H.	Biggs				Lo	ottie	e Gill			
<u>a</u>	shot sand N is mai		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Street	and Number	er or Rural	Route Numbe	er, City or T	own, State, Zi	ip Code)
	and and n 27		Jennings Nic	hols/So			Hillto					2192	
ב כ	ges 1 t of H If iter or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal fror	n State		osition (Name of matory or other pla			ate		tion - City or T	
	t. Pac tmen tant: tant:		4 □ Donation 5 □ Other (S				Cemete	-		5,200)7 E	1kton	, MD
ם ם	permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other trau		21. Signature of Funeral Service	Licensee			2. Name and Addre	G. Ge	e Fi				
Χ,	Att,	Ġ	23a. Part1. Enter the disease, or	complications that	t caused the					Elkt respiratory ar		MD 2	1921 Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to	o (or as a coi	nsequence of):							
	Examiner	ž.	Sequentially list conditions	b									
	Pa #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a coi	nsequence of):							
	ecute and I-trans	Examiner	that initiated events resulting in death) Last	c	o (or as a co	nsequence of):							
	icate be executed physician and s the burial-transit	a E			. (,							
000	ficate p phys s the	edical		d									
5	nding use a	N/u	IF FEMALE: 23b. Was decedent pregnant		outcome pf pr		75-1				230	d. Date of deli	very
Ď	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 X No		e birth 2 egnant at time		⊒Ectopic pregnand ⊒ Other <i>(specify)</i>					Month	Day Year
5	at the by th tache	hys	9 ☐ Unknown 1							T			
<u>,</u>	res thi igned be de		Part II. Other significant conditi	ons contributing to	death but no	-	ınderlying cause gi	ven in Part I	l.	23e. Did to			the cause of death?
COLOS,	requi	ted	Chronic	back									
מ	elaw hasb le2sl	Completed by	Devere C	steo por	10515					24a. Was	SV	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
5	r: Th ficate r, pag		05.74								rmed? 2 No	1 ☐ Yes	2XNo
>	slcial certif	Be C	25. Was case referred to medica examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient	2 ∏ER/Outpatie	nt 3 DOA Ot	hor.		<i>(Check only o</i> ne 5□ Resid		Other (Coes	(, 3)
5	y Phy er this eral d	7: To	27. Manner of Death	28a. Dat	te of Injury	28b. Time of				8d. Describe I			ary)
5	ath. r: Aft	atio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	igation	onth, Day Ye	ar) Injury		Yes 2]No				
1015171	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ningd 200. I la	ce of injury - ilding, etc. (S	At home, farm, st pecify)	reet, factory, office		2	8f. Location (S City or Tox	Street and I vn, State)	Number or Ru	ral Route Number,
2	oital o urs aft eral D		20-0-15	ng Physician: To t	Un a land of ma	v konsvinden den	the appropriate that	time data a			(-)		atata d
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical		Examiner: On the									
	To the within To the complex	Me	29b. Signature and title of certific	er .			29c. Licen	se number			29d. Date s	signed (Montt	n, Day, Year)
)	-		I H Sext	Q Marite	ten	o mo	Doc	536	75		7/3	2/07	
			30. Name and address of person	·			= : .:>			Kton.	me	219	7.
			Robert A. 31. Date filed (Month, Day, Year,	Monte	Registrar's	Signature /		ST .	21	►70 n.	V / 12	17	4
	Sta Registi		JUL 5 2	007 Sen	we s	Signature	w						
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		1 - State Registrar	e of Maryland / Dep <i>Ce</i>	artment of He		Reg	J. No.	23270
Physici /Medi		1. Decedent's Name (First, Middle, Last) Mary Matilda	Nichols			2. Date of Death Month July	9 2007	3. Time of Death 11:47A M
Examir Funeral Director	ier	4a. Facility Name (If not institution, give street at Caroline Home for Home 5. Social Security Number 6. Sex 219-14-4940	ospice 7. Age (In yrs. last birthday)	Ab. City, Town, or L Denton If Under 1 Year Months Days	ocation of Death If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Sept 10	Year) Co	hplace (State or Foreign untry) ryland
aryland show	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 XYes 2 ☐ No
with the M s or 28a-f be notifie	Director	Maryland Caroline 10e. Street and Number	Greensb	10f. Zip Code		100	g. Citizen of What Co	puntry?
d within 72 hours after death with the Maryland gjene. er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 □ Married 1 □	s Decedent Ever in U.S. 13. ed Forces? Yes 2X No ss, Give r or Dates:	21639 Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 ₺ No	panic Origin? (Spo , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	
d within giene. er than "	Completed	08	ege (1-4or 5+) (Give life.	edent's Usual Occupat e kind of work done du DO NOT use retired) nemaker	uring most of work	ing	6b. Kind of Business/	Industry
be do	To Be (17. Father's Name (First, Middle, Last) James Edward Ross				e (First, Middle, Ma C. Irelan	,	
d 2 should Ith and Men 7 Is markettraumatic	_	19a. Informant's Name/Relationship (Type. Prin		ing Address (Street ar			•	
Pages 1 and 2 should ent of Health and Mer nt: If Item 27 Is marke ry or other traumatic		Grace Anita Chance/ of 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	20b. Place of Disp cemetery, cre	Dutchman's osition (Name of ematory or other place int Cemeter)	Date 2	o. Maryla Oc. Location - City or [illsboro.	Town, State
permit. Pages 1 Department of F Important: If Ite any Injury or ot		21. Signature of Funeral Service Licensee		22. Name and Address 1leegle and 20 Box 160	of Facility Helfent	ein Fune	ral Home,	PA
Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not en	nter the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
eath certificate be execujed attending physician and for use as the burial-trainsit	edical Examiner	Sequentially list conditions, it ary, leading to finite diatecture. The first cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of): ue to (or as a consequence of): ue to (or as a consequence of):					
The law requires and the death certificate has been signed by the attending page 2 should be detached for use as is	Physician/Mec	in the past 12 months?		□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
uires, nat i signed by ld be detai	by	Part II. Other significant conditions contribution	g to death but not resulting in the o	underlying cause give	n in Part I.			o the cause of death?
	Completed					24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of s 2 □ No
ding Phys	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital 27. Manner of Death 1 Natural 5 Pending investigation	1 Inpatient 2 ER/Outpatie Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other	r: 4 Nursing Ho	h (Check only one ome 5 Resider 28d. Describe how	nce 6 Other (Spe	ecify)
To the Hospital r Attend within 24 hours a 'er death To the Funeral Director: completely filled in by the t	Certification:	2 Thousant C Could not be	Place of injury - At home, farm, s building, etc. (Specify)			28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
e Hospital 24 hours a e Funeral I letely filled	Medical	(Check only 2 Medical Examiner: Or one) an	To the best of my knowledge, dea n the basis of examination and/or i d manner stated.	nvestigation, in my op	oinion, death occur	red at the time, da	ate and place, and du	e to the cause(s)
To the within 2 To the complet	Me			29c. License	number 538/5	29	d. Date signed (Mon	th, Day, Year)
(30. Here and address of person who complete KoRAH M. Pull	d cause of death (Item 23a) (Type MOD MD); 9 32. Regin ar's Signature	Print) D MA	RKET S	T; DEN	TON MI	02/629
St. Regist	ate	31. Date filed (Month, Day, Year)	32. Regir dar's Signature	Socie	-			

4b. City, Town, or Location of Death

Baltimore

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV 12, 1916

3. Time of Death

9. Birthplace (State or Foreign

South Carolina

10d. Inside City Limits 1 XYes 2 No

4c. County of Death

Baltimore

USA

Black, White, etc.

Month

Day

1 ☐ Yes 2 ☐ No

Year

Black

1:15 AM

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matified at

Physician

/Medical

Examiner

4a. Facility Name (If not institution, give street and number)

6 Sex

1 □ M 21X F

711 Academy Road

5. Social Security Number

237-07-2547

Physician /Medical Examiner

The law requires that the death certificate be executed and director, after death

Division or Vital Records, P.O. Box 68760,

Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Maryland Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 Academy Road 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify. <u>ک</u> Specify. 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Domestic Worker/Laborer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Byas Gertrude Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Byars (Nephew) 8513A Greenbelt Road #202, Greenbelt MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Cemetery 7/6/2007 Baltimore, MD 22. Name and Address of Facility Latimore Funeral Services, P.A. 21. Signature of Funeral Service Licensee alimore 9013 Annapolis Road, Lanham MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Gangrene foot disease or condition resulting in death) Due to (or as a consequence of) Peripheral Arterial Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Arteriosclerotic cardiovascular disease Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2XNo 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WILKENS AVE, BALTIMORE MD 21229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMBANDAM BASKARAN 3455

7. Age (In vrs. last birthday

90

State

ō

e Funeral

within 2.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

0 5 2007

32. Registrar's Signatur

State Registrar 31. Date filed (N

onth, Day,

Registrar's Signature

07-05314 Jos

e Luis Perez		State of Maryland / Department of							7 0007
20.0 . 0.0-		For State Certificate o		,	J	Reg. N			7 2327
\ Physician		egistrar . Decedent's Name (First, Middle,Last)			2. Date	of Death		ear	3. Time of Death
edical Examine	er	Jose Luis Perez, II			July	10, 2007			2216 hrs
-	4	a. r dollay realise (in not motionally, give street and member)	4b. City, Town, of Baltimore	or Location of Death			4c. County	y of Death	
		University of Maryland Medical Center	If Under 1 Ye	ear If Under 24Hrs.	8 Date	of Birth (N	IM/DD/YYY	yy 9. Birth	place (State or
Funeral Director	1	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Da		1	o. 11,		Foreign	ntry) NC
Director	Ļ	246-39-8461 1XM 2F 24 Yn	S		Tex	J. 11,	1703		7, 110
· · · · · · · · · · · · · · · · · · ·	~	Jsual Residence of Decedent 0a. State 10b. County 10c. City, Town or Loca	tion						10d. Inside City Limits
how se		MD Baltimore Freeland							1 Yes 2X No
arylar	Director	0e. Street and Number	10f. Zip Code		-	10g.	Citizen of V	What Coun	try?
death with the Maryland or items 23a or 28a-f show any must be notified at once.	5	20434 Gore Mill Road	2105	3		ט	.S.A	. •	
with ms 23 be no	- La	15.00	as Decedent of F	lispanic Origin? (Sp an, Mexican, Puerto I	ecifý Ye Rican, e	s or No- tc.)		ce - Americ	an Indian, Black,
death or ite	Funeral	Never Married 2 Married 1 Yes 2 X No						Wh	ite -
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36 hin 72 than	影		too Ar	tist -			Вос	dy Ai	ct
d with year with year wither the Me	Completed	17. Father's Name (First, Middle, Last)		18.Mother's Name	,				
218 be file ntal H rked	8	Jose Luis Perez, Sr.		Laura			_		
hould hould is ma	٥			eet and Number or R					
MC 2 slath at alth at 27 mm 27 samms	1	Laura R. Huggins 2043 20a. Method of Disposition 20b. Place of Dispo			Date				Town, State
Ore, es 1 a of He If ite	-1	1 X Burial 2 Cremation 3 Removal from State Mt Cremators or C	n Unite	_{ed} Jul	<u>y</u> 1	6,	Freel	and,	MD
tim E. Pag tment rtant:	1	4 Donation 5 Other Specify: Methodis	t Cemet	ery 20			_	1000	rtuary, Inc.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral/Service Licensee	2.4 Seco	nd St., N	J. Jew	Free	dom.	PA 17	'349
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter							Approximate Interval Between Onset and
/Medical	- 1	failure. List only one cause on each line. Immediate Cause (Final disease a. Head Injuries with Complications							Death
taminer	-	or condition resulting in death) Due to (or as a consequence of):							
	ᆡ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			_				
	Examiner	if any, leading to immediate Due to (or as a consequence of): Course Ernar Underlying Course (Disease or injury that initiated							
15 E C	۱ä	events resulting in death) Last Due to (or as a consequence of):							
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O, e be ex ysician burial	ğ						23d. Date	of deliver	/
68760, certificate be noting physic as the bur	[]	20th 184 de-endered engagement in the	etal death	3 Ectopic pregna	ancy		Month		Day Year
Box 68760, a death certificate be the attending physici ed for use as the burited for use a	<u>Ş</u> .	4 Pregnant at time of death 5	Other (Specify)			_			
he dea	Physician/Medical	Part II. Other significant conditions contributing to death but not resulting in the	e underlying caus	se given in Part I.	23	Be. Did toba	cco use co	ontribute to	the cause of death?
Records, P.O. Be The law requires that the de cate has been signed by the page 2 should be detached f	آھ	Tarini on the organization of the organization	, ,		1	Yes	2 🗸 No	3 Pro	oably 4 Unknown
rds, require	Completed				24	a. Was an		b. Were at	topsy findings available
COF law r has b	흵				46	autopsy perform	ed?	death?	
		25. Was case referred to medical	26.PI	ace of Death (Check		Yes 2	INO .	1 🗸 Y	2 110
of Vital Records, ng Physician: The law requir After this certificate has been a neral director, page 2 should	B	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatie		Othor	ng Home		esidence	6 Othe	r:
of \ing Phy	입	27. Manner of Death 28a. Date of Injury (Month Pay Year) 28b. Time of	of Injury 28c.	Injury at Work?		escribe ho		curred	
_ = . ~ = .	흲	2 Assident Investigation	1	Yes 2 ✔ No					
Division tal or Attendi rs after death. al Director: /	ij	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, offic	ce building, etc.	28f. Lo or	cation (Str Town, Sta	eet and Nu te)	mber or R	ural Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after death. Finneral Director: After this certifitely filled in by the funeral director,	Certification:	4 Homicide determined (Specify) School Grounds				Town, Sta			
Divisior To the Hospital or Attend within 24 hours after death To the Finneral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc (Check only one) 2 Medical Examiner: On the basis of examination and/or investi	curred at the time	e, date and place, and nion, death occurred	d due to at the tir	the cause(me, date ar	s) and mar id place, ar	nner as sta nd due to ti	ted. ne cause(s)
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier		ense number					onth, Day, Year)
	_	111 1	0.	C.M.E.			July 11,	2007	
		30, Name and address of person who completed cause of death (Item 23a)							
4			Penn Street	t, Baltimore, MD	2120	1			
\ St	ate	31. Date filed (Morth, Day, YQr) 2007 3 Registrar's Signature	ide						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		epartmer Certificat			and Mei	ntal Hy		g /m m, pm	000	n 1
			Registrar 1. Decedent's Name (First, Middle, Las	st)				Journ	2.	Date of De	Reg. No	-	3. Time of D	eath !
	Physicia /Medic			ouise Pippi	n				J	Month	25 25	2067	1535	М
	Examin		4a. Facility Name (If not institution, give	1				Location o	of Death		4c.	County of Death		
	Funeral		5. Social Security Number 6. S		n yrs. last birth	day) If Unde	- QST er 1 Year	If Under	24 Hrs. 8.	Date of Bi (Month, D	rth Vacal	1albot 9. Birth	place (State or I	Foreign
	Director		218-01-1239	□M 2只F	87 Y	Months	Days	Hours	Min.	larch	23, 1	1920 Ma	ryland	
	and w		Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town	or Location							10d. Inside City	Limits
	Maryli -f sho fied at	tor	Maryland Caroli	ine	Federa	ulsburg							1 ☐ Yes 2	⊋ _{No}
	th the or 28a e noti	Director	10e. Street and Number			10f. Zi	p Code					izen of What Cou		
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at		26750 Line Road	T 40 W - D d - 4 5	-:110		632	ion onio Ori	=in2 (Cnaolf	Vec or N		ed State		reric
	ter de items iner m	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No	r in U.S.	13. Was Dece If Yes, spe			gin? (Specif n, Puerto Ric	can, etc.)	0-	Black, White		
036	ours af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	21 No	Specify:				Specify: Cauc	casian	
2-0	72 hc "natul dical	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. D	Decedent's Usu Give kind of wi life. DO NOT u	ual Occup	ation during mos	t of working			ind of Business/li	ndustry	
121	filed within 72 Hygiene. ther than "naf the, the Medic:	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		seamstr		"/			CLOX	thing Manufa	cturina	
nd 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	Be C	17. Father's Name (First, Middle, Last,)				18. Mothe	er's Name (F	irst, Middle	e, Maiden		3	
\Zar	should be and Mental s marked o umatic eve	To E	George Pe	ernell Dean					Grace				247	2.2
η	12 sho		19a. Informant's Name/Relationship (**	1	•	•				-	or Town, State, Z USburg,		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Ann Neal 20a. Method of Disposition	Daughter	20b. Place of to cemetery				Date			ocation - City or T		
$f_{i}\rho_{\rho}$	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	JHemoval from State		rd Ceme			6/28/2	2007	Cond	cord, Ma	ryland	
alti	permit. Pa Departmer Important: any Injury once.		21. Signature of Funeral Service Licer	7 1 1/1 A		22. Name a	and Addres	ss of Facili	ty	D 4			· ·	
æ	80 E E 6		23a. Part1. Enter the disease, or com shock, or heart failure. List only	11/02		12 Sou	th S	econd	Street	et, M	arylo	and 2162	9 Approximate	
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	e death. Do no	of enter the mo	de oi dyin	ig, such as	Cardiac or i	espiratory	arrest,		Interval Between Onset and De	een eath
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	onseq nce of	nen	al	dist	use	_				
N.	Examiner		Requestable list a celificate	Hyper	ensing	Nep	hos	den	055					
	ed sit	iner	Esquentially list on diffune, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (drasa c	onsequence of): /	1 / 1	1						
-	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last	c. On Son as a co	onsequence of	<u>heart</u>	- Ga	/UV						
8760	icate be executed physician and s the burial-transit	dical E		d. Hyperk	Kalenia	Ĺ								
9	ertifica ing ph e as th	Med	IF FEMALE:	00										
Box	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1☐Live birth 2 ☐ 4☐Pregnant at tim	Fetal death	3 ☐Ectopic 5 ☐ Other (s		/				23d. Date of deli Month		ear
P.O.	the de	nysic	1 Yes 2 No 9 Unknown	9 Unknown										
	w requires that the death certifit been signed by the attending t should be detached for use as		Part II. Other significant conditions	contributing to death but n	not resulting in	the underlying	cause giv	en in Part I				use contribute to		
ord	require een si bould b	ted	Ityper tension	1						1]Yes 2		obably 4 □Ur	
3ec		Completed by								24a. Wa aut	s an opsy formed2	24b. Were au prior to death?	topsy findings av completion of car	vailable use of
a	ificate or, pag		25. Was case referred to medical					26 Place	e of Death (1□ Yes	2/2 N	o 1 ☐ Yes	2□No	
Ę	ysicia is cert directe	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outp	patient 3□ D	OOA Oth	or				6 ☐Other (Spec	cify)	
Ö	ng Ph ifter th ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Ti	jury	28c. Injur Wor			d. Describe	e how inju	iry occurred		
Division or Vital Records,	Attending r death. ector: After by the funer	icati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b		- At home far	M street factor	_	Yes 2□		f Location	(Street a	nd Number or Ru	ıral Boute Numb	per.
Divi	after of Direction by	Certification:	4 Homicide determined	28e. Place of injury building, etc. ((Specify)	iii, street, idoto	ory, office		20	City or T	own, Stat	re)	rar route reamb	,01,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s	Medical C	29a. Certifier 1 Certifying Pi (Check only one)	hysician: To the best of r miner: On the basis of ex and manner stated	xamination and	death occurre l/or investigation	ed at the ti	me, date a opinion, de	nd place, an ath occurred	d due to th	e cause(s e, date ar	s) and manner as id place, and due	stated. to the cause(s)	
	ro the vithin го the comple	Me	29b. Signature and title of certifier	and manner states		2	9c. Licens	e number			29d. Da	ate signed (Monti	h, Day, Year)	
	V		H.L. CIMPIA	1 m			200	150	176	7_	61	125/0=	7	
			30. Name and address of person who		th (Item 23a) (T	Type, Print)	_	Ede	176 i	200				
-8	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature ,		A. o		70/11/	1)				
	Pegiet		IIIN a S	2007	Man A									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** lantier 50 2:55A^M 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Admiral Annaplis If Under 1 Year | Younder 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 10,1939 Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 👿 F KANSAS 67 Director 560 52 5342 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TYes 2 □ No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 604 ADMIRAL DRIVE APT. 640 21401 UNITED STATES Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

14☐ Yes 2☐ No 1958—
If Yes, Give
Year or Dates: 1960 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 200 No Aq. Specify: 3 ☑ Widowed 4 ☐ Divorced 1960 WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) 12 College (1-4or 5+) FEDERAL GOVERNMENT ADMINISTRATIVE ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN ELOISE GLEASON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traum once. KEITH B.PLANTIER 4 MILLHAVEN CT. EDGEWATER, MD. 21037 (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 14 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) RESTHAVEN MEMORIAL PRK 07-03-07 LUBBOCK, TEXAS 21. Signature of Funeral Sourice Licensee 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 X No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perform 1□ Yes 2ZNo Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Injury 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ပ 3 ne Rd Suk 300 Annapol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +(VA

Registrar

State

31. Date filed (Month, Day,

03

DHMH 17 Rev 1/2001

State

Registrar

0 5 2007

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

431 Center Street

Lynn Allison Rockwell

4a. Facility Name (If not institution, give street and number)

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

sician and burial-transit the death certificate be executed attending physician the as

Division or Vital Records, P.O. Box 68760.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1□M 2₩F 218-94-0195 56 Director Oct 25, 1950 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It is a 72 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at other traumatic benotified at 1 ☐ Yes 2 ☐ No Director Maryland Frederick Frederick 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 431 Center Street 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2X No white Specify Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurice Harlan Rockwe11 Helena Mae Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Zarger - friend 5736 Industry Lane, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any Injury or ott 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State Stauffer Crematory 7-2-2007 Frederick, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sen Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List Styling cause on each line. 23a. P. 11. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): resulting in death) Last Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2X No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) THU Nopuyen, 1564 oposmutoun 32 negistrar's Signature 31. Date filed (Month, Day, Year) 06 2007 Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

7. Age (In yrs. last birthday,

4b. City, Town, or Location of Death

Frederick

2. Date of Death

June 29,

Day

2007

4c. County of Death

Frederick

3. Time of Death

8:40 A.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.-Time of Death Day Year **Physician** July 2, <u>Virginia Irene Reed</u> 2007 /Medical 8:47 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bet<u>hesda</u> Montgomery 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Director 82 220-14-3106 Oct. 13, 1924 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminant. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo Directo Maryland Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2855 Florence Road 21797 Funeral USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Worker Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ John Frank Renn Mabel Catherine Becraft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bonita J. Reed, daughter 2855 Florence Road, Woodbine, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery 17/7/2007 Mt. Airy, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part : nt+r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (Final disease or condition resulting in death) Physician Acute Myocardial Infarction 7 hours /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Occlusion 7 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dus to (or as a nonsequence of) Examine Atherosclerotic Coronary Artery Disease 20 years resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 2047 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown page 2 should 107 Completed 7/2/ 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1☐ Yes 2**X** No 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 2 ER/Outpatient 3 DOA GINI

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. Division or Vital Records, P.O. neral Director: / To the Funeral C

27. Manner of Death 5 ☐ Pending investigation

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

D0017436

July 3, 2007

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kunick M. Kenh

MD, 8600 Old Georgetown Road, Bethesda, Maryland 20814 Kenneth M. Kent,

31. Date filed (Month, Day, Year) JUL 0 6 2007

6 ☐ Could not be determined

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

18

W RE

State

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Ross B. Rolark, Jr. July 2007 6:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐M 2 ☐ F Vrs **Director** 81 458-22-4474 2, 1925 Texas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Marvland | Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7301 Central Ave. 20743 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: ģ Specify: 3 € Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 l U.S. State Department Elementary/Secondary (0-12) College (1-4or 5+) Government 12 should be filed w n and Mental Hygier 18 marked other th <u>Inspector</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev Ross Rolark, Sr. 2 Beatrice Block 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley J. Rolark/Son 8599 Ritchboro Rd., Forestville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 7/7/2007 Brentwood, MD 21. Signature of Furial Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. En or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or con filon resulting in death) Acute Myo Carchal **Physician** /Medical Due to (or as a con quence of): Examiner atheroscleratic Winner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9☐Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an certificate has autopsy performed' 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pl 24 hours after death. e Funeral Director; After ti After t 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide thin 24 hours at 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical 0 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 1328 Sontrem avenue 32. Registrar's S

of certifier

DHMH 17 Rev 1/2001

(Check only one) 29b. Signature and

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Sur 12 310

29c. License number

D00 55 120

29d. Date signed (Month, Day, Year)

3rd 2007

July

was hington DC 20032

			1 - For State Registrar	State of Maryland		ficate of		vientai Hy	giene Reg. No.	2017	23281
	Physici	an	1. Decedent's Name (First, Middle, Last)		-			2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	RALPH WILLIAM 4a. Facility Name (If not institution, give s		4	b. City. Town. o	r Location of Death	JULY		200 / County of Death	9:57P M
	Examin	er	FREDERICK MEMORIA			FREDE			F	REDERICK	
4	Funeral Director		720 07 0220	M 2□F 7. Age (In yrs. last		f Under 1 Year flonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	**************************************	.923 Pla	place (State or Foreign Tryland
	land bw t		Usual Residence of Decedent 10a. State 10b. County		own or Locati	ion					10d. Inside City Limits
	a-f sho	ctor	Maryland Frederic	k Fred	erick						1 Yes 2 No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 322 Willow Avenu	e		10f. Zip Code 21	701		10g. Citiz U.S	en of What Cou	ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	d by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ☑No If Yes, Give Year or Dates:	I	s Decedent of Hes, specify Cub	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0- 1	4. Race - Ameri Black, White Specify: Whi	etc.
15-0	n 72 h "natu edical	letec	15. Decedent's Educ (Specify only highest grade		6a. Deceden (Give kind life. DO	t's Usual Occup d of work done NOT use retire	ation during most of wor d)	king	16b. Kin	nd of Business/Ir	ndustry
212	d withii giene. r than the M	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		rvisor	2)		Coun	ity Gove	rnment
Maryland 21215-0036	uld be filed Mental Hyg rked othe tlc event,	To Be Completed by	17. Father's Name (<i>First, Middle, Last</i>) Paul Henry	Stream			18. Mother's Nan Sarah	ne (First, Middle Cather			
, Mary	and 2 sho salth and I 1 27 Is ma er trauma		19a. Informant's Name/Relationship (Type Mrs. Margie L. Str	ream, wife	322 W	Jillow A	and Number or Ru Ave., Fre	derick,	MD 2		p Code)
Baltimore,	Pages 1 ann of He ant: If Item		20a Method of Disposition AB Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State 20b. Place cernic	e of Disposition etery, cremate PLeasa	on (Name of ory or other place int Ceme	tery Jul	y 16, 2	20c. Loc 007	cation - City or T Taylors	own, State town, VA
Balt	permit. Departr Importa any Inj		21. Signature of Funeral Service License	MO025	5 106	eeneyda East (ind Basfo Church St	rd PA F	unera erick	1 Home , MD 21	701
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.				,			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acute R	Renal	fai	Iure Mami				1Day
	Examiner			Due to (or as a consequen	Pseu	domen	mani	us C	oliti		4 Days
,	pi ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen							
13	tificate be executed g physician and as the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequen	ce of):						
68760,	e be e sician e buris	edical E	C ⊲								
			IF FEMALE:								
Вох	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use	by Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 4□Pregnant at time of deat	eath 3⊟Ed	ctopic pregnanc ther (specify) _	у		2	3d. Date of deliving Month	ery Day Year
P.O.	the de	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	II 300	ther (specify) _				<u></u>	
S, D	uires that the de signed by the a ld be detached f	by Pi	Part II. Other significant conditions con	tributing to death but not resultin	ng in the unde	rfying cause giv	en in Part I.	23e. Did			the cause of death?
ord	w requir been si should i	ted						1 🗆	Yes 2	No 3□ Pro	bably 4 Unknown
Division or Vital Records,	has b	Completed						24a. Was		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
ta	an: Ti tificate tor, pa	Be Co	25. Was case referred to medical				26. Place of Dea	1□ Yes	2 X No	1 ☐ Yes	2 No
<u> </u>	nysici nis cer i direci	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ☐ ER	/Outpatient	3□ DOA Oth	er.			□Other (Spec	ify)
0 0	Ing Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Inju		28d. Describe	how injury	occurred	
isio	death ctor: y	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At home	, farm, street		Yes 2□No	28f. Location	Street and	d Number or Rui	al Route Number,
<u>≥</u>	al or A s after al Dire	Certification:	4 Homicide determined	building, etc. (Specify)	,	, , ,		City or To	wn, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my knowle er: On the basis of examination and manner stated.	n and/or inves	stigation, in my	opinion, death occi	urred at the time	, date and	place, and due	to the cause(s)
	To the Comp	Ň	29b. Signature and title of certifier	Ž		29c. Licens	se number		29d. Date	signed (Month	, Day, Year)
						9	17071		7	-13-07	
			30. Name and address of person who con	maleted serves of death (Itam 00	(a) (Type Pri	- 43				0	
	10		Said Za	id imm	801	TOLL	House	- Ave,	Fre	derick,	MD 21701
	\0 Sta Registr			idimn	801	TOLL	House	Ave,	Fre	derick,	MD 2170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	•	epartment of H Certificate of L		lental Hygier Reg. I	1) 11,17	23281
	Physici		Decedent's Name (First, Middle, La BARBARA	JEAN	1 9	CHROEDER			Day Year 2007	3. Time of Death 7:10 A M
Jimes	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of Death	
			5429 Broadway			N	orrisvi	lle	Har	ford
	Funeral Director		5. Social Security Number 6. S 555–54–0016	Sex 7. Age	(In yrs. last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yei 9/7/193	9. Birth Cou	place (State or Foreign ntry) ifornia
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location				10d. Inside City Limits
	Maryl 1 ehc	ō	MD. Hart	ford		Bel	Air			1 ☐ Yes 2 No
	r 28e	rec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	h with	a D	1003C Jessic	a's Cour	·t	21	014	τ	Inited S	tates
36	d within 72 hours after deeth with the Maryland Jiene. r then "natural", or Iteme 23a or 28e-f e how The Medical Examinat must be notified at	y Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N	ver in U.S.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Spen, Mexican, Puerto		14. Race - Ameri Black, White	can Indian, , etc.
8	hour tural	ed b	15. Decedent's E	Year or Dates:	162	Decedent's Usual Occupa	ation	165	. Kind of Business/Ir	hite
Maryland 21215-0036	within ene. then "	Completed by	(Specify only highest grant (0-12) 1.2	Coflege (1-4or 5	+)	(Give kind of work done of life. DO NOT use retired LTSING ASS	during most of worki)	ng	Nurs	•
0	e filed Il Hygi other	BeC	17. Father's Name (First, Middle, Last)				(First, Middle, Maid		
<u>a</u>	A 20 0 6	To B	Harry	L.	Mose	s	Adeli	ne	Gons	alves
a	2 should and Men le marke aumatic	•	19a. Informant's Name/Relationship (Type, Print)	196.	Mailing Address (Street a	and Number or Rura	al Route Number, Cit	y or Town, State, Zi	p Code)
	1 and 2 Health em 27 l		Susan S. Walsh	n (Daught		29 Broadw		ite Hall		21161
ore	of Heal		20a. Method of Disposition 1 ABurial 2 Cremation 3	Removal from State	cemetery	Disposition (Name of y, crematory or other place	θ)		Location - City or T	
altimore,	. Pag tment tant:		4 ☐ Donation 5 ☐ Other (Special	y) H	lighvie	w Mem. Ga				
Ba	permit. Pages I Depertment of H Important: If Ite eny Injury or ot once.		21. Signature of Funeral/Service Lick	n Kurt		E.G. Ku	0	arrettsv on Funer		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each in	Θ.			or respiratory arrest,		Approximale Interval Between
Œ	Physician		Immediate Cause (Final disease or condition	a	jogra	n's Dize	150			Onset and Death
	/Medical Examiner		resulting in death)		consequence	n): pares 3				
		70	Sequentially list conditions, if any, leading to immediate	b	T consednence o					
1	d Insit	Examiner	Cause (Disease or injury	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,				
, ,	exection and ital-trig	Еха	that initiated events resulting in death) Last	C. Due to (or as a	a consequence o	f):				
68760,	ficate be executed physicien and s the burial-transit	edical	(_ d						
_			IF FEMALE:							
P.O. Box	The law requires thet the death certisise has been signed by the ettending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 1 □ Pregnant at 1 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
rds, P	quires thet an signed b	by	Part II. Other significant conditions of	contributing to death bu	at not resulting in	the underlying cause give	en in Part I.		o use contribute to t	
Division of Vital Records,	a 2 C1	Completed	Depr	ession				24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
Ž	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Death	61 92 92		Daughter
o	Phys r this ral dii	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatier			4 Unursing Hor	me 5 Residence 28d. Describe how in		Home
5	Attending in death. ector: After by the fune.	tlon	1 Natural 5 Pending 2 Accident investigatio	(Month, Day	Year) In	jury Work	res 2 □ No	EUG. DUSCHDU HOW II	ilary occurred	
	Attendir death.	ifica	3 Suicide 6 ☐ Could not b	e 28e. Place of Inju	ry - At home, far	m, street, factory, office		28f. Location (Street		al Route Number,
5	s after al Direct	Certification:	4 Homicide determined	building, etc	. (Specify)			City or Town, St	ate)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Attenthis certificate he completely filled in by the funeral director, page	edical (29a. Certifier (Check only one) 1 Cartifying Pr 2 Medical Exam	nysician: To the best on ninar: On the basis of and manner sta	examination and	death occurred at the time	ie, date and place, a pinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due t	stated. o the cause(s)
)	To t To t	Σ	29b. Signature and title of configer	M.D.		29c. License	- 7-0		Date signed (Month,	
	7		30. Name and address of person who				& Pd; S	Suite 102	Tous	ian, MD
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 9 200	7 Registra	r's Signature	back				

			For State Registrer	State of Maryland		irtment of He tificate of D		1.0	ene 007	23282
	Dhooisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Rolana	l Edward Seth	Sr.			July 9	2007	11:45 A M
	Examin		4a. Facility Name (If not institution, give st.	reet and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
			Ruxton Health of De			Denton If Under 1 Year	If Under 24 Hrs.	0.0	Caroli	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia M 2□F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,)	(ear) Co	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	76				lovember 28	1930 Man	yland
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Man -f sh filed	ţo	Maryland Caroline	,	Presto	n				1 □ Yes 2 ☑ No
	r 28g	irec	10e. Street and Number		TESLU.	10f. Zip Code		10	g. Citizen of What Co	untry?
	within 72 hours atter death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at	Completed by Funeral Director	22016 Wood Wharf Ro	ad		21655		Un	ited Stat	es of Americ
	ems ems	ner		2. Was Decedent Ever in U.S		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spen. Mexican, Puerto I	cify Yes or No-	14. Race - Ame Black, White	rican Indian,
9	or It	F	1 ☐ Never Married 2 ☐ (Married	Armed Forces? 195 17 Yes 2 No If Yes, Give 195 Year or Dates: 195	/ -	1 □ Yes 2/☑ No	Specify:		Specify:	,
21215-0036	ural',	q p	3 Widowed 4 Divorced	Year or Dates:	,,	/ (Bl	ack
5	"nat	lete	15. Decedent's Educa (Specify only highest grade	completed)	16a. Deced	lent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of workir	ng 10	5b. Kind of Business/	industry
2	within ene. than	μ̈	Elementary/Secondary (0-12)	College (1-4or 5+)		etaker			Junicipal 1	Pank
0	filed Hygie other ent, II	ပိ	17. Father's Name (First, Middle, Last)				18. Mother's Name			wat
au	should be nd Mental marked o	To Be	Clarence	Seth			Emma	Thomas		
Maryland	shound M	-	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	ng Address (Street a			City or Town, State, 2	Zip Code)
	and 2 ealth a n 27 ls		Josephine A. Seth	Wife	2201	6 Wood Wh	are Road.	Preston	, Marylan	1 21655
J. C	of He		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natary or other place Castern Castern Cameter	D. D	ate 2	Dc. Location - City or	
Ē	Pages nent of ant: If It ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	ryländ Forans	Castein .	Shore 7/16	/2007 #	urlock, M	asuland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licenses	///	33	Name and Address	s of Facility	пΔ		yeu
<u> </u>	89 2 2 9		Mandapul.	Noone	1	2 South S	econd Str	eet, Dên	ton, Mary	land 21629
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	. Do not ent	er the mode of dying	, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition	DYSRH	YTH-	1 MIMIA	1			SELONDS
	/Medical Examiner	4	resulting in death)	Due to (or as a consequ						144.00
	LAGITITIE	ъ.	Sequentially list nonditions b.	ISCHEU	111	C4201	omyopi	XHIT		Y=4RS
	per list	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequ	ience orj.	CAM	010 VASC	4.0	Dur	VIL A DS
	xecul and al-trar	xan	that initiated events c. resulting in death) Last	Due o (or as a consequ	ience of):	rectife	0 60 0112C	GLIFE	12751	VEINE S
8760,	eath certilicate be executed attending physicien and for use as the burial-transit	dical E	d							
68	iticate g phy as the	edic	0.							
Вох	death certitic e attending p id for use as	N/	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnancy			23d. Date of del	
	9 9 5	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		Other (specify)			Month	Day Year
<u>o</u>	that the ed by th detache	hys	9 Unknown							
Ś	S C 0	by	Part II Other significant conditions cont	nbuting to death but not resu	ulting in the u	nderlying cause give	n in Part I.	1	cco use contribute to	
ord	w requires been signi should be	ted	VERTEICALAR	TITCHYCHE	OINT			1 Yes	2 □ No 3 □ Pr	obably 4 Unknown
Vital Record	s b	Completed by Physician/Med	LOZOLARY 14	etery D),5EA	555		24a. Was an autopsy	prior to	topsy findings available completion of cause of
<u>=</u>		Co						perform 1 🗆 Yes 2	ed? death?	2 / No
VII.	Physician: Th r this certiticate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death			
of	Phys rthis ral dii	٠ <u>۲</u>	1 ☐ Yes 2 🛣 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time of	IL 3LI DUA	4 Nursing nor	ne 5 □ Resider 28d. Describe hov	ice 6 Other (Spe viniury occurred	cify)
on	ding h. Atte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work			,,	
Division	or Attanding Physician: after death. Director: Atter this certilio: I in by the tuneral director.	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho				28f. Location (Stre	et and Number or R	ıral Route Number,
á	at or A s after of in b	Certification:	4 Homicide determined	building, etc. (Specify	′)			City or Town,	State)	
	To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by			ician: To the best of my knower: On the basis of examinat						
	the H in 24 the F nplete	Medical	one)	and manner stated.	ion and or in					
	To To	2	29b. Signature and title of certifier	1.	165	29c. License	number	11	d. Date signed (Mont	n, Day, Year)
			The Landon	IN TITELDI	roll	クラン	2 201	7	1-10	0/
			30. Name and address of person who cor	npleted cause of death (Item	23a) (Type,	Bonk	WING DA	u A	JE 10 042	ALSBURL
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis at's Signa	ture	1 10-				
	Registr	ar	anr 1 ()	2007 Sam	15	Alimenah.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yea **Physician** 26 PM 21 cward EW:S SEORGE 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Wicomico ALISBURY KEGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days 1**/2**M 2□ F 214-34-8141 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at MD ARION 1 ☐ Yes 2 No JUMERSET Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21838 Wayman 5051 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 2 No Maryland 21215-0036 Specify 15 lack þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) abolêr 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othwany Injury or other traumatic event, 17. Father's Name (First, Middle, Last) oshur > Leward ulia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ni:fe Marion Magnolia Steward Wayman RD MO 5051 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 Removal from State Marion, MD John Wesley Cemelry 07-07-2007 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Anthony E. Ward Funeral Home 21. Signature of Funeral Service Licensee risfield, MD 21817 314 COUS ST C 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** 18 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the SS IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2**№** No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendl 24 hours after death. Funeral Director: A death. 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

State Registrar

Sivakumar Kaman M.D.

31. Date filed (Month, Day, Year)

32. Regis ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year) 32. Register's Signature

JUL 0 5 2007 Market

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 23:30 PM John Harold Schwallenberg 23 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rehabilitation and Extended Care Ctr. Baltimore 8. Date of Birth (Month, Day, Year)
Jan. 5, 1923 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Maryland Director 216-16-2207 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Marvland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 524 Wilson Road 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 XXes 2 □ No 194 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1943-1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: Be Completed by 1946 White ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Boat Carpenter Boat Building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Schwallenberg Gertrude Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. Schwallenberg / Son 524 Wilson Road Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Nation | 2 □ Cremation | 3 □ Removal from State | 4 □ Donation | 5 □ Other (Specify) Crownsville Vet. Cem. 7/3/2007 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) cher4 /Medical Due to (or as a correquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the aftending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the after in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown mellit Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Moultanou autopsy performed; death? 1 ☐ Yes 2 ☐ No 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: (Month, Day Year) 1 Matural 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Ho within 24 h To the Fu

Registrar

31. Date filed (Month, Day, Year)

Mourie

29b. Signature and title of certifier,

3900 Lock Reven Bird. Baltimore 1710 21218

JUL 0 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature Glam & Sport

29c. License number

29d. Date signed (Month, Day, Year)

06/28/2007

		For State Registrar	State of Mar		ertificate of		, ,	lene eg. No. 2 () () 7	23285
Physicia /Medic		1. Decedent's Name (First, Middle, La Franc	est) Lis Asbury S	tevens			2. Date of Dea Month JULY 2	Day Year	3. Time of Death 2:30Ā. M
Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Dea	
	B	VA MARYLAND HEAD 5. Social Security Number 6.		TEM (In yrs. last birthda		PERRY PO.T			CIL
Funeral Director	9	245-40-4450 Usual Residence of Decedent	AFT N OFF	7 Yrs.	Months Days	Hours Min.	(Month, Day Oct. 20	, Year) Co , 1929 No	thplace (State or Foreign ountry) rth Carolina
aryland show d at	-	10a. State 10b. County		I Oc. City, Town or					10d. Inside City Limits 1 1 Yes 2 □ No
the M 28a-f notifie	Director	Maryland Harfo	or d	nav.	re de Grac		1	log. Citizen of What Co	
3a or	Ϊ́	614 Franklin Str	eet			21078		U.S	
ems 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13	B. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an. Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
filed within 72 hours after death with the Maryland Hygiene. wher than "natural" or items 23a or 28a-f show ent, <u>the Medical Exa</u> miner must be notified at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: 1 S		1 ☐ Yes 2 ☒ No	Specify:	,	Specify:	White
72 ho 'natur dical E	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	16a. Dec	edent's Usual Occup le kind of work done DO NOT use retire	oation during most of wo	rking	16b. Kind of Business	/Industry
within ene. than "	mp.	Elementary/Secondary (0-12) unknown	College (1-4or 5+) unknown	life	. DO NOT use retire Warehou			unkno	own
filed v Hygie other i		17. Father's Name (First, Middle, Las					me (First, Middle,	Maiden Surname)	
Acntal	To Be	Lowel	l Stevens				Julia Ni	ichols	
2 shou and N Is ma auma		19a. Informant's Name/Relationship						r, City or Town, State,	, ,
l and lealth im 27 ther tr		Richard B. Steven	ns (Brother)		Gebe Lane	, Hender		North Car 20c. Location - City or	Colina 28792
Pages i ent of H nt: If ite ry or of		20a. Method of Disposition 1 Burial 2 □ Cremation 3 (4 □ Donation 5 □ Other (Spec		cemetery, co	rematory or other pla son Forest is Cemeter	07/		•	Ls, Maryland
permit. Pages 1 and 2 shoult be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatil event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	ACTA EAC	- <- I	22. Name and Addre	ess of Facility terson &	Son Fune	eral Home,	P.A.
Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line	ne death. Do not e		ng, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death UNKNON
/Medical Examiner			•	consequence of): ITVER A	ND KIDNEY				
p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·	consequence of):	CATALON DIST MC	MADE DIC	IDA CO		
be executed sician and burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	C	consequence of):	rive PULMC	DNARY DIE	DEASE		
ficate be ex physician s the burial			d						
he law requires that the death certificate te has teen signed by the attending physage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pl 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death	B □Ectopic pregnanc □ □ Other (specify) _	у		23d. Date of de Month	elivery Day Year
uires that i signed by d be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	ven in Part I.		bacco use contribute t	o the cause of death?
he law requir e has teen s ige 2 snould	Completed						24a. Was a autop perfor 1 Yes	sy prior to	utopsy findings available completion of cause of
an: tificate tor, pa	Be Co	25. Was case referred to medical				26. Place of De	1 Yes ath (Check only or		s 2 No
nyslot nis cer direc	To B	examiner? 1 ☐ Yes 久 ☐ No	Hospital: 1 ☐ Inpatient	t 2 ☐ ER/Outpat	ent 3 DOA Ott	ner: 4 Nursing I	Home 5 ☐ Resid	ence 6 □Other (Spe	ecify)
Attending Physician: r death. ector; After this certific by the funeral director,		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time	/ Wo			ow injury occurred	
al or Atte after des Il Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, farm, (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	lural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (Physician: To the best of aminer: On the basis of a and manner state	examination and/or					
To t To t	Σ	29b. Signature and title of certifier	Hasl	rni	29c. Licens	D24648	2	29d. Date signed <i>(Mon</i>	
4		30. Name and address of person who SHER A. HASHMI,				E SYSTEM	PERRY P	POINT, MD 2	1902
Sta	te								
Registi	ar	593 03	32. Registrar 5 2007	ever so.	Maria				

			1 - For State Registrar	State o	of Marylan		artment of H tificate of L		ınd Menta	al Hygien	000	7.23285
	Physici /Medic Examir	cal	Decedent's Name (First, Middle Hell) 4a. Facility Name (If not institution)	en Stanl			4b. City, Town, or	Location o	Jun	ie 29,	2007 	6:35A M
	Funeral Director		National L ⁵ . Social Security Number 578-12-2275	utheran 6.Sex 10 M XOF	Home 7. Age (In yrs. 92	last birthday) Yrs.	Roc If Under 1 Year Months Days	kvil If Under 2 Hours	24 Hrs. R Da	te of Birth onth, Day, Yea t . 12,	Monto 1914 W	omery Birthplace (State or Foreign Country) Jash., DC
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Md . Mon 10e. Street and Number	tgomery	10c. Cit	y, Town or Lo R	cation OCKV111	e		10a. (Citizen of What	10d. Inside City Limits X Yes 2 No
036	ba filed within 72 hours after death with the Maryland hat hygiene. Id other than "natural", or Itams 23a or 28a-1 show event, Its Modical Exarcitet must be multified at	by Funeral Director	9701 — Veir	12. Was Dec Armed For rried 1 Yes	ive		208 Was Decedent of Hi f Yes, specify Cuba		gin? (Specify Yo , Puerto Rican,		USA	merican Indian, hite, etc.
nd 21215-0036	Hygi hygi other ent, I	Be Completed	(Specify only higher Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle,		1-4or 5+)	(Give life.	lent's Usual Occupa kind of work done of DO NOT use retired ir Dres	furing most) SET 18. Mothe	r's Name (First	, Middle, Maide		ss/industry Pressing
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Baltimore,	permit. Pagas Depertment of Important: If it any injury or o		'4 □ Donation 5 □ Other (3 21. Signature of Funeral Service	Specify)	Res	22		s of Facility	, Inc. $\frac{2}{10}$	222-W	linton iscons gton, E	in Ave.,NW
	zate be exacuted whysician and hysician and the buriat-transit	Examiner	23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	cate of the death each line. ON G (or as a consequence of as a consequence of a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequenc	Uence of): TE uence of):			cardiac or respi	iratory arrest,	9 00117 1	Approximate Interval Between Onset and Death Onset and Death MO 50 YEARS
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	requires been sign should be	Completed by P	Part II. Other significant condit		leath but not res	ulting in the u	nderlying cause give	en in Part I.		X □ Yes 4a. Was an	2 No 3 2	e to the cause of death? Probably 4Unknown autopsy findings available
Division of Vital Records,	Physicien: rthis certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 □ Yes 2√ No 27. Manner of Death	Hospital		ER/Outpatien		er: 4 💢 Nu	of Death (Che		death	es 2□ No
Division	el or Attending Ph. s after death. sl Director: After thi ed in by the funeral of	Certification;	3 ☐ Suicide 6 ☐ Could	igation not be 28e. Place	nth, Day Year) e of Injury - At ho ling, etc. (Specif	Injury ome, farm, str y)		(? Yes 2∐1	28f. Lo	cation (Street ty or Town, Sta		Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Medical (oinion, deat		he time, date a	nd place, and o	
2	2 1 1 2 2	-	30. Name and address of person	JMU who completed cau	se of death (Item	23a) Пуре,	0	005		7	TULY '	5, 2007 VILLE, MD
	Sta Registi		OR. SAM		Registrar's Signa	tiva de	7101	10	-11/5	,,,,		

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Physicia	_	Registrar 1. Decedent's Name (First, Midd	le,Last)				-		2	. Date of D		See	وإدث	3. Time of Death —
dical Exami		John Garrett	Seaton							Month June 26	5, 2007	/ Year		1235 hrs
		4a. Facility Name (if not institution 317 Leafmoor Court	on, give street and nu	mber)		4b. City, To Pasad		ocation of	Death			4c. County of Anne Aru		-
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under		If Under		8. Date of	Birth(M	M/DD/YYYY)	9. Birth	place (State or
Director		217-56-5939	1XM 2F	57	Yı	Months	Days	Hours	Min.	Mar.	25,	1950	Cour	htry)Maryland
*		Usual Residence of Decedent		140-00										
vith the Maryland 23a or 28a-f show any notified at once.	'n	10a. State 10b. County MD Anne	Arundel		Town or Loca sadena									10d. Inside City Limits 1 Yes 2 X No
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h with	Funeral	11. Mantal Status	Armod E	edent Ever in U.S		as Deceden Yes, specify					No-	14. Race White		an Indian, Black,
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15-0036 iled within 77 Hygiene. d other than	ם	12	,			Solde	erer					GOI	ıld	
5-0(ed wi tygier other	Š	17. Father's Name (First, Middle	, Last)					3.Mother's	Name (First, Midd	le, Maid	en Surname)		
121 be fil ental t rrked	Be	Robert Nelson										ne Lev		
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t. Pag		4 Donation 5 Other S 21. Signature of Funeral Service		CE	edar H			-	20	07		Brook	lyn,	ΜD
Balt permit. Departi Importi		21. Signature of Funeral Service			Ba	Name and A	0 &	Sons	, P.	A. S				uneral Hom
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/Medical		failure. List only one cause Immediate Cause (Final disease	00-40-40	unshot Woun	d of Left T	Thigh								Between Onset and Death
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F ≯ F 8	Me	29b. Signature and title of certifi		VIA	 	29c.	License	number			29	d. Date signe	ed (Mon	th, Day, Year)
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10.1		30. Name and address of person	1 1	,										
5(4)		Susan Hogan MD.	Assistant Medic	cal Examiner	111 Pe	enn Street	, Baltir	more, N	1D 212	:01				

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

JUL 0 3 2007

ORIGINAL

		1 - State Registrar				Ce	rtifica	te of l	Death			Reg. No	.Z. U U	1	2320
		1. Decedent's Name (First, Mide	dle, Last)								2. Date of D	eath Da	V	ear	3. Time of Death
hysicia /Medic		Au	ıdrey	Mae	Sherr	ard					June	30,	2007		6:00 p
xamin		4a. Facility Name (If not institution	on, give stree	t and nun	nber)		4b. City	, Town, or	Location	of Death		40	. County of I	Death	
		Stella Maris		e			1	Timor						lti	more
neral		5. Social Security Number	6. Sex 1 ☐ M			s. last birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	rth ay, Year,	9.	Coun	
ector		165-22-3449 Usual Residence of Decedent			81	115.					May 1,	192	26	Pen	nsylvania
		10a. State 10b. Count	ty		10c. C	City, Town or Lo	ocation							1	0d. Inside City Limi
T I	ŏ	Maryland C	ecil					Perr	vvil	le					1 ☑ Yes 2 ☐ N
쿌	Director	10e. Street and Number					10f. Zi	p Code				10a. Ci	tizen of Wha	Lt Coun	trv?
9 4		1459 Perryvil	le Road	đ					21903					s.A	•
	Funeral	11. Marital Status	12. V	Was Dece	dent Ever in	U.S. 13.	Was Dece	edent of Hi	ispanic Ori	gin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race		
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any injury or conce.		21. Signature of Funeral Service	e Licensee	080	E. 182	/ L		Pat	terso	'n &	Son Fu			e, P	.A.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **TAYLOR** JUNE 27 2:30 P M 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HEARTLAND NURSING HOME ADELPHI MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □XM 2 □ F 579-96-3403 MARCH 10, 1965 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No MONTGOMERY ADELPHI MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 UNITED STATES METZEROTT RD. 1801 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 Widowed 4 Divorced Specify: **BLACK** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BILLY TAYLOR DORETHEA PETERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORETHEA TAYLOR/MOTHER 1418 4th St., LANHAM, MARYLAND 20786 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEMORIAL PARK 7/3/07 4 Donation 5 Dother (Specify) LANDOVER, MD 21. Signature of Funeral Service License 22. Name and Address of Facility CAPITOL MORTUARY leath. Joh, t enter the mode of dying, such as cardiac or respiratory arrest, D.C. 23a. Part1. Enter the diseas of complications that caused lie death. shock, or heart failure. List only one cause on each lind. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a dissequence of): tract infection Due to (or as a consequence of): Gaueritally flat on ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Suprapubic catheter for bladder dysfunction cerebral palsy F FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? dysphagia 2 No 3 Probably 4 Unknown feeding gastrostomy tube 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2☒ No autopsy performed? Yes 2 (1)No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be I

r 28a-f show notified at

Director

Funeral

Completed by

Be

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Examine

P.O. Box 68760,

Division or Vital Records,

burial-tran physician the as page 2 s certificate After

Physician/Medical ò Completed Be Certification: To e Hospital or Attending P 24 hours after death. e Funeral Director: After t mpletely filled in by Medical

within 24 hours at To the Funeral D

State Registrar

to Communicate verbally 1 Yes 21.

26. Place of Death (Check only one) 25. Was case referred to edical examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify)

28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29c. License number D34511

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah R. Schneider. 1220 A. E. Jappa Rd. Svite 230 Towson, MD 21286 MD

31. Date filed (Month, Day, JUL 0 5 2007

29b. Signature and title of certifier

1 ☐ Yes 2€ No

6 Could not be determined

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

32. Registrar's Signature

		State of Maryland / Department of Health Certificate of Death		al Hygien Reg. N	$\angle UU$	7 2	3290
		Decedent's Name (First, Middle, Last)		te of Deeth	ву Ус	ar 3. T	ime of Death
	Physician /Medical	CAROLYN V. THOMPSON	7	7	1 0	· ·	37 PM
	Examiner	4a Fecility Neme (If not institution, give street end number) 4b. City,	Town, or Location	of Death 4	c. County of I	Death	
			IDOVER		PRINC		
	Funeral	Months Days Hours	er 24 Hrs. 8. Dat Min. Mc	e of Birth onth, Day, Yea	9.	Birthplece (S Country)	State or Foreign
	Director	577-72-2646	10	/1/52		WASHI	NGTON,
	pu ≱	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location				10d. Ins	side City Limits
	faho faho or	MD PRINCE GEORGES LANDOVER				X	Yes 2□No
	Tech Tech	10e. Street end Number 10f. Zip Code		10g. C	itizen of Wha	t Country?	
	Sa di	7298 MAHOGANY DRIVE 20785		IT.	S.A.		
	me 2	11. Maritel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C	Origin? (Specify Ye	s or No-	14. Race - /	American Indi	ian,
20	s 1 and 2 should be filed within 72 hours efter death with the Maryland if Healith and Mental Hygiene. If Healith and Mental Hygiene is not items 23a or 28a-f show other traumstic event, the Medical Examinat must be notified at To Be Completed by Funeral Director	Armed Forces? If Yes, specify Cuban, Mexic 1 □ Never Merried 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify Year or Dates:		etc.)		Vhite, etc. BLACK	
21215-0020	tural stars	15 Decedent's Education 16a Decedent's Usuel Occupation		16b.	Kind of Busin	ess/Industry	
15	in 72	(Specify only highest grede completed) (Give kind of work done during mo	ost of working	1.55		,	
212	be filed within 72 hor tal Hygiene. d other than "natura event, the Medical Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) 2 MANAGER			DCHA		
פ	other of the C	17. Father's Neme (First, Middle, Last) 18. Mot	ther's Name (First,		n Sumame)		
<u>a</u>	Mental Mental of the stice of t	WILEY DICKSON JR. B	EULAH G	RAHAM			
Maryland	and A	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num					
	and 2 saith a n 27 is	MICHAEL THOMPSON/SON 7298 MAHOGANY	DR. LAN	DOVER	,MD 2	0785	
ore.	of He	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. i	ocation - City	or Town, Sta	ate
	Peges nent of ant: If its ury or o	4 Donetion 5 Dother (Specify) HARMONY MEM. PARK	1 "	/07LA			
<u>a</u>	permit. Peges Department of Important: If it any injury or o	21. Signature of Funeral Service Licensee 22. Name and Address of Fac					
m	9 Q F # 9	6500 ALLENTO	WN RD.	CAMP S	SPRING	GS, M	D 20748
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	as cardiac or respir	atory arrest,		Appro	ximate al Between
4	Physician					Onset	t and Death
	/Medical Examiner	Immediate Cause (Final disease or condition disease or condition disease or condition disease or condition described disease or condition disease or condition disease or condition disease or condition disease or condition					
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	licate be executed I physicien and Is the bunal-trensit edical Examin	Sequentially list conditions, Due to (or as e consequence of): if ery, leading to immediate cause. Enter Underlying				į	
58760,	sicier sicier buni	Cause (Disease or injury					
		resulting in death) Last Due to (or as e consequence of):				ì	
Box	r requires thet the deeth centification been signed by the attending should be deteched for use estered by Physician/Me	d				<u> </u>	
n i	deeth	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	rt I. 23	b. Did tobecc	o use contril	oute to the ca	ause of death?
0	by the teacher			1 🗆 Yes	2 No 3[Probabiy	4 Unknown
	requires thet been signed b should be dete eted by PI						
ם ס	equin		24	a. Was an autoperformed?	opsy 2	4b. Were auto available	prior to
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<u> </u>	nysician: The law list certificate has I director, pege 2 s			1 ☐ Yes	ZNo	1 🗆 Yes	2□ No
of Vital	entific ector,	examiner?	ice of Death (Chec	k only one)			
			Nursing Home 5			Specity)	
_	B 9 9 C	27. Menner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work?		scribe how inj	ary occurred		
200	tor: / the tree	2 Accident investigation 3 Suicide 6 Could not be		cation (Street a	nd Number o	r Pural Pouts	Alumbor
DIVISION	la or Attending Price is effer deeth. In Director: Affer the din by the funera Certification:	4 ☐ Homicide Suicide 4 ☐ Homicide	City	y or Town, Ste	le)	i nuiai nouie	i iyamber,
-	ours filled	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and due	to the ceuse(s) and manne	r as stated	
-	ne Hospi in 24 hou ha Funer pletely fill	(Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, de end manner stated.	eath occurred at th	e time, date ar	d place, and	due to the ca	use(s)
	To the Hospital of Artendary within 2 Hours effect deeth. To the Furneral Director: Aft completely filled in by the fur	29b. Signature and title of certifier 29c. License number	r	29d. D	ate signed (M	fonth, Dey, Yo	aar)
		D280	79	JUI	LY 2,	2007	
0	(5) (30. Name end address of person who completed cause of death (Item 23) Type, Print)					
4		FRANCINE HIGGS-SHIPMAN, MD U 9200 BASIL CT	. LARGO	, MD 2	20774		
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signat					
	Registrar	JUL 0 5 2007 General D. Specks					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Made ranere 200 4b. City Town, or Location of Death 4c. County of Dea Name (If not institution, give street and number) Hours Min. 8. Date of Birth (Month, Day, Y If Under Months 9. Birthplace (State or Foreign 5. Sociel Security Number 7. Age (In vrs. lest birthday) 6 Sex Deys 1 M 2 □ F MARYLAND 1922 85 218-14-3074 Usuet Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 1 No ANNAPOLIS MARYLAND ANNE ARUNDEL 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21409 996 WESTWAY DRIVE UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11 Merital Status 1XIYes 2 □ No If Yes, Give WORLD Year or Dates WAR II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) UNITED STATES Elementary/Secondary (0-12) College (1-4or 5+) MILITARY CIVIL ENGINEER 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) HANNAH CECELIA SHELTON JOSEPH EDWARD TRAVERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHIYA TRAVERS/WIFE 996 WESTWAY DRIVE, ANNAPOLIS, MARYLAND 21409 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition CHELTENHAM VETERANS 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State JULY 9, 2007 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND CEMETERY 22. Name and Address of Facility FEILOWS HELFENBETN & NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESIGATE 21. Signature of Funeral Service Licenses M00672 ROAD, ANNAPOLIS, MARYLAND 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) Due to (or as a consequ e of Sequentially list conditions, for y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tb (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4x Unknown 3 Probably 1 ☐ Yes 2 ☐ No monney 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 12 No 1 ☐ Yes 2 ☐ No 1 Tes

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

10a. State

Funeral

Director

or 28a-f

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deeth v

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. Important: If tem 27 is marked other than "ne any injury or other traumatic event

3altimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

traumatic event, the Medical Examiner must be notified a

Physician/Medical Examiner

ettending physician en for use es the bunal-transit is cartificate has been signed by the e diractor, page 2 should be detached it this death.

Be Completed by

State

Registrar

Attending Physician: The law requires that the death certificate be axecuted eral Director: After thi filled in by the funeral 5 Hospital C To the Hospital within 24 hours a To the Funeral C completely filled

Medical Certification: To

29a. Certifier

1 Yes

27. Menner of Death

2 Accident

4 Homicide

3 Suicide

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

Hospital:

28a. Date of Injury (Month, Day Year)

Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23a) (Type, Print

31. Dete filed (Month, Day, Year)

25. Was case referred to medical examiner?

20 No

0 3 2007

28b. Time of

DHMH 16 Rev 6/95

		ı	1 - For State Registrar	State of N	Maryland		rtment of H tificate of I			iene _{eg. No.} 2 (007	23292
Ì	Physici		1. Decedent's Name (First, Middle, Last) Helen Eliz		an Fos	sen			2. Date of Deat July 10		Year	3. Time of Death 5:45 PM M
)	/Medic Examin		4a. Facility Name (If not institution, give s Glade Valley Nursing a	street and numbe and Rehabi	n Litatio	n Cente	4b. City, Town, or Walke	Location of Death	1	4c. Count Fred	y of Death erick	
	Funeral Director		5. Social Security Number 212-38-9438 6. Sex	х 7. <i>A</i>	Age (In yrs. Ia 96	as <i>t birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1 ⁴ 9¶1	9. Birth Mary	place (State or Foreign
	D	or	Usual Residence of Decedent 10a. State 10b. County Maryland Freder:	ick	10c. City	, Town or Lo	walker:	sville				10d. Inside City Limits 1X1Yes 2 □ No
	h with the N 3a or 28a-l st be notifi	Funeral Director	10e. Street and Number 56 West Frede:		reet		10f. Zip Code	21793	1	0g. Citizen of U .	What Cou	intry?
036	be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ሺ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	ş?] No		Vas Decedent of H f Yes, specify Cuba I ☐ Yes	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Bla	ice - Ameri ack, White, Whit	
27275-0036	I within 72 ho jiene. r than "natur t he Medical I	Completed	15. Decedent's Edu (Specify only highest grad	cation ie completed) College (1-4o	er 5+)	(Give life. L	lent's Usual Occup kind of work done o DO NOT use retired emaker	ation during most of wor f)	rking	16b. Kind of E		
_	0 = 0 %	To Be C	17. Father's Name (First, Middle, Last) James McLaren						ne (First, Middle, I Elizab			nberger
, Mary	and 2 should be salth and Mental 27 Is marked er traumatic ev		19a Informant's Name/Relationship (TV Nancy E. Van Fo	pe. Print) OSSEN/D	aught	19b. Mailin er 9	g Address <i>(Street</i> II Cher	and Number or Ru Okee Tr	ail, Fr	, City or Town ederi	CK,	MD 21701
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic es		20a. Method of Disposition 1 ☐ Burial 2 ☐ X remation 3 ☐ F 4 ☐ Ponation 5 ☐ Other (Specify) 21. Signal (re of Funeral Service Licens		⊎SmitΫ́	isbur;			ly 12,		Smit	hsburg, M
g	Department of the concession o		Kubard C.C.	Busta			Pame and Addresser and Addresser Addresse Addresser Addr		· · · · · · · · · · · · · · · · ·	•	me MD 21	
)	Physician /Medical		23a. Part1. Enter the disease, or compleshook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause do/each a.	ed the death line. 2001 C as a consequ	AIN	er the mode or dyir	ig, such as cardiae	c or respiratory arr	est,		Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b	as a consequ							
8/60, 2	ficate be executed physician and s the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a consequ	ience of):						
O. Box 68	The law requires that the death certificate the has been signed by the attending phy agge 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 roonths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcon 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal t at time of de	death 3	Ectopic pregnancy Other (specify)	1			ate of deliv	very Day Year
1	quires that t n signed by uld be detad	by	Part II. Other significant conditions co	-	n but not resu	ilting in the ui	nderlying cause giv	en in Part I.	23e. Did to			the cause of death?
Vital Hecords,		Completed	Hepo Hynos	180					24a. Was a autop perfor 1∐ Yes	sv .	o. Were aut prior to co death? 1 □ Yes	topsy findings available ompletion of cause of
or VII	Physician: r this certifica ral director, I	To Be	I les SK 140	Hospital: 1	atient 2 🗆 I	ER/Outpatier	t 3□ DOA Oth	er: 4 Nursing H	ath <i>(Check only or</i> fome 5 ☐ Resid		ther (Spec	rify)
DIVISION 0	ng (fter	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		Day Year)	28b. Time of Injury	Wor	yat k? Yes 2∐No		treet and Nun		ral Route Number,
S	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifying Phy					me, date and place	City or Tow		manner as	stated.
	the Hos hin 24 ho the Fun npletely	Medical	(Check only 2 Medical Exami	iner: On the basis and manner	s of examinat	tion and/or in	vestigation, in my o	opinion, death occ	urred at the time, o	late and place	e, and due	to the cause(s)
	Voiti	_	1.	suguer			D4	0307		9d. Date sign July 1		
_	4			ande, M.	.D., 1	564 Op	ossumtow	n Pike, l	Frederic	t, MD 2	21702	
	Sta Regist		31. Date filed (Month, Day, Year)	32 legi	istrar's Signa	ture	ill!					

DHMH 17 Rev 1/2001

	,	For State Registrar	State of	of Marylan		artment of F		ind Me	-	giene Reg. No.	200	my 15 c	20
Physici	an	Decedent's Name (First, Middle,	,						2. Date of De Month	ath Dav	Year		
/Medi	cal	4a. Facility Name (If not institution,		. Wesle	y, Jr.	4b. City, Town, o	r Location of		Ju1y	13 [°]	2007 County of Dea) A ^M
LXaiiiii	ici	Laurelwood Ca	re Center			E1ktor					Cecil		
Funeral Director		5. Social Security Number 261-75-1937	6. Sex 1 🖾 M 2 🗆 F	7. Age (In yrs. 47	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da July 18	y, Year)	0	rthplace (State Country) aryland	or Foreign
aryland show dat	١	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	ocation			-			10d. Inside C	City Limits
th the Ma or 28a-f	Funeral Directo	Maryland Ceci	L	E	1kton	10f. Zip Code				10g. Citiz	en of What C		
ath wi	<u>ra</u>	241 East Main				21921						States	
perilliole, Marylating ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status 1 X Never Married 2 Marri 3 Widowed 4 Divorced	Armed F	2 ∭ No ive		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Orig an, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)		Black, Wh	erican Indian, ite, etc. Black	
I 3-UU30 n 72 hours af "natural", or edical Exami	Completed to	15. Decedent (Specify only highes	s Education t grade completed,)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	nation during most d)	of workin	g	16b. Kin	d of Busines		
I within liene.	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)		t Applica				No	t App1	icable	
Waryland ZIZIS 12 should be filed within 7 h and Mental Hyglene. 7 is marked other than "n	BeC	17. Father's Name (First, Middle, I	.ast)				18. Mother	r's Name	(First, Middle	, Maiden S	Surname)		
yial ould b Ment arked	2	John T. Wesley	•						R. Wil				
Mar nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationsh Gladys R. Wesi		r		_{ng Address (Street} Skipjack				, ,	, , , , , , , , , , , , , , , , , , , ,		
Daillinore, permit. Pages 1 a Department of Hec mportant: If item any injury or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐Removal from	State Bo	Place of Disponentery, cre	osition (Name of matory or other place Manor	ce)	Ju1y	18,	Ches	apeake	r Town, State	
alling mit. Pa bartmer sontant: rinjury		4 ☐ Donation 5 ☐ Other (S _p 21. Signature of Funeral Service I		Cei	meterv	2. Name and Addre		2007 Euro	mo1 = 1	Mary	land_		
any per on one		Daved	S. Hu	ka		os W. Sto					. Mary	land 21	921
Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that only one cause on	caused the deat each line.	1	ter the mode of dyin		cardiac o	r respiratory a	rrest,		Approxima Interval Be Onset and	ate etween I Death
/Medical Examiner		resulting in death)	Due to	(or as a con	uence f):								
y led _ ried _ risit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	, , ,	(or as a conse	uence of):								_
icate be executed physician and street burial-transit	dical Exa	resulting in death) Last	C	(or as a conseq	juence of):								
oo/ ifficate g phys	edic		d										
J. BOX 06/ le death certificate the attending phys hed for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome pf pregna birth 2 □ Feta gnant at time of c nown	al death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			2	3d. Date of d Month	elivery Day	Year
w requires that the de been signed by the should be detached	by	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	underlying cause giv	ven in Part I.		23e. Did	,		to the cause of	
law requires been signal to should the	eted								24a. Was			autopsy findings	
The la ate has page 2	Completed								auto		prior to death	o completion of	cause of
VIII sician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 4		150/0-4-46	oth Oth			(Check only				
ng Phys	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date	Inpatient 2 e of Injury nth, Day Year)	28b. Time of Injury	III 3 DOA	4/3/ NU		ne 5 Res 28d. Describe			pecity)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	ation ot be 28e. Plac	e of injury - At heding, etc. (Special	ome, farm, st	M 1 □	Yes 2∐1		28f. Location (City or To	Street and wn, State)	1 Number or	Rural Route Nu	mber,
Hospita 24 hours Funeral etely filled	edical C		Examiner: On the			th occurred at the ti nvestigation, in my							e(s)
To the within To the	Me	29b. Signature and title of certifier		0)	29c. Licens	se number			29d. Date	e signed (Mo	nth, Day, Year)	
		> /h	Sal	eler	/		261	83		201	4 10	6,20	07
\		30. Name and address of person Madhu Sachder		use of death (Iter 22 £ Cec		1	EAST	T n	nd. 2	1901			
St	ate	31. Date filed (Month, Day, Year)		Registrar's Sign		and o							

		For	State of	Marylan	-			d Mental Hy	giene		
		1 - State Registrar			Cer	tificate of L	Death		Reg. No.	007	2020
Physici	an	Decedent's Name (First, Middle,	, Last)					2. Date of De Month	ath Day	Year 7	3. Time of Death
/Medio	cal	Charles	Augus			Weaver 4b. City, Town, or		July	12 Ac Count	y of Death	1,13 /-
Examin	ner	4a. Facility Name (If not institution, Washington Cour					stown	saui			- on
Funeral				7. Age (In yrs. i	last birthday)	If Under 1 Year	If Under 24 H		th	shingt 9. Birthpl	ace (State or Foreign
Director		215-26-8137	1 X M 2□ F	76	Yrs.	Months Days	Hours M	May 9,	1931	Mary	
pu ,		Usual Residence of Decedent		too Cib	y, Town or Lo	nation				14/	Od. Inside City Limits
anyla shov	5	10a. State 10b. County									1 X Yes 2 □ No
the M 28a-f notifie	Director	MD Washi 10e. Street and Number	ngton	на	gersto	Wn 10f. Zip Code			10g. Citizen of	What Coun	trv?
with a or	ä	332 Wakefield H	0.4				0		U.S		
.0036 hours after death with the Maryland tural", or ttems 23a or 28a-f show al Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13. \	2174 Vas Decedent of Hi	-	(Specify Yes or No uerto Rican, etc.)		ce - America	
or Iter		1 ☐ Never Married 2 ☐ Marrie	Armed For ed 1 📉 Yes If Yes, Giv	2 No 195	52	f Yes, specify Cuba □ Yes 2X No	Specify:	uerto Rican, etc.)		ack, White, e	etc.
5-UU36 72 hours af "natural", or	d by	3 X Widowed 4 ☐ Divorced	Year or Da	ates: 195	54	L 165 241140	ореспу.		Speci	Whi	te
72 h 72 h "natu dical	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Deced	lent's Usual Occupa kind of work done o OO NOT use retired	ation during most of	working	16b. Kind of E	Business/Ind	ustry
vithin 72 ene. than "nather Medicial"	E D	Elementary/Secondary (0-12)	College (1	-4or 5+)	1	:/Operato:			Automo	ntive	
yland 2 ould be filed v I Mental Hygie larked other t latic event, th		17. Father's Name (First, Middle, I	Last)		0 11 11 11			Name (First, Middle,	L		
land ld be file ental Hy ked oth	To Be	Lewis Franklin	Weaver				Eva E	llen Seco	ord		
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hyglene. Iftee 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh	nip (Type. Print)	·	19b. Mailir	g Address (Street a	and Number or	Rural Route Numb	er, City or Towr	n, State, Zip	Code)
and 2 ealth a n 27 is		Ragan Shaw/Exec	utor		1301	Cedarwo	od Driv	e, Hagers	stown, N	MD 21	742
ges 1 ges 1		20a. Method of Disposition 1 M Burial 2 □ Cremation	3 □Removal from 9		Place of Dispo cemetery, cres	sition (Name of natory or other plac	e)	Date	20c. Location	- City or To	wn, State
Pages Pages ment of lant: If its		4 □ Donation 5 □ Other (Sp				n Cemete		16/2007	Hagers		
Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service L	icensee	2		. Name and Addres	-	Rest Have a Ave., Ha			
La la la la la la la la la la la la la la		23a. Part1. Enter the disease, or shock, or heart failure. List (complication that ca	aused the death						WII, MI	Approximate Interval Between
Physician		Immediate Cause (Final	_	Dige.	Fore	Call	omo	13 Cel	e com	1000	Onset and Death
/Medical		disease or condition resulting in death)	_	or sa consequ	uence of):	3900	91110	13 000	OBIC	COL	D af
Examiner		Se uentially list conditions,	b	_	\mathcal{H}	re lu	19				
) B = 5	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of).						
be executed iclan and burial-transit	Examin	that initiated events resulting in death) Last	c	or as a consequ	uence of):						
cate be executed physician and the burial-transit					,						
ficate ficate physics the	edical		0.								
.U. BOX 687, the death certificate y the attending physiched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come pf pregna		Tatania necessaria			23d. D	ate of delive	ry
deatl	icia	in the past 12 months? 1 □ Yes 2 □ No		irth 2 ☐ Feta ant at time of d		Ectopic pregnancy Other (specify)			N	fonth	Day Year
at the	hys	9 🗆 Unknown									
	þ	Part II. Other significant condition	ins contributing to de	eath but not resi	ulting in the ui	hiderlying cause give	en in Part I.	23e. Did t	es 2 No		e cause of death?
ecords, law requires t as been signe 2 should be o	sted	Service III		L	, , ,			_		3 🗆 F10D	ably 4 ☐Unknown
The law rate has b	Completed	Karnologi	ical h	recrus	e of	the t	emu	24a. Was	osv	. Were autoperior to condeath?	osy findings available npletion of cause of
		0							ormed? 200 No		2 No
Or VITA Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	Z	ED/O. to otion	t 3 DOA Othe	or:	Death (Check only o			
- a a	7: To	1 Yes 27 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	28c. Injun	y at	g Home 5 Resi	dence 6 ∐O: how injury occu		/)
VISION Attending r death. ector: Afte	tio	1 □ Natural 5 □ Pending 2 □ Accident investig	4	th, Day Year)	Injury	M 1	k? Yes 2 □ No				
DIVISION I or Attending after death. I Director: After d in by the fund	ifica	3 Suicide 6 Could n 4 Homicide determi	200. FIAU	of injury - At ho ng, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (ber or Rura	l Route Number,
tal or saffe	Certification:			ng, etc. (opecn	,,			Only of 10	wii, State)		_
Hospi 4 hour Funer ely fill	edical	(Check only 2 Medical I	g Physician: To the Examiner: On the ba	asis of examina							
DIVIS To the Hospital or Atte within 24 hours after de. To the Funeral Directo completely filled in by th	Medi	one) 29b. Signature and title of certifier	and man	ner stated.		29c. License	e number		29d. Date sign	ed (Month	Dav. Year)
5 ≥ 5 8		255. Signature and the or certifier	هدره	rus		1149	LSR	8	July	13	4 2007
,		30. Name and address of person v	who completed cause	e of death (Item	n 23a) (Tune	Print)	0	9		1	1-01
71		A	OUA, T	D. 25	1 6	Print) Antie	cham	st. He	sider	now	$n, \pi $
Sta Regista		31. Date filed (Month, Day, Year)	2007 K	egistrar's Sign	ture .	Server Contraction					
negisti	004	002 4 0 .		990	-/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-05298 State of Maryland / Department of Health and Mental Hygiene Christopher Willey 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 10, 2007 0925 hrs Medical Examiner istopher 4b. City, Town, of Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Dorchester Cambridge 5233 Skip Jack Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Days Min. Months Hours Country) Maryland Director 213-94-4750 1 / M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No iten 27 is marked ofher than "naturph", or items 23a or 28a-f show traumatic event, the Medical Exteniner must be notified at once. asto alb MTDirector 10g. Citizen of What Country? 10e. Street and Number 2160 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 2 1 No Yes Specify: 4 Divorced Yes 2 No specify: ac If Yes, Give Year 3 Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) permit. Pages I and 2 should be filed within 72 hou.
Department of Health and Mental Hygiene.
Important: If item 27 is marked others. Elementary/Secondary (0-12) College (1-4 or 5+) Supermarke Stockperson 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, Cit. or Town, State, Zip Code) Terri Henry William 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, Terri amono 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 7/20/07 4 Donation 5 Other Specify:
21. Signature of Funeral Service Licensee e Marsh Cemetery HENRY FUNERAL HOME, PA 23a. Parl I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD. 21613 Approximate Interva Physician Between Onset and /Medical Death a. Methadone intoxication and morphine and ethanol use Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or se a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 7,28a-f, perME, g869,7/20/07 TT attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year Month 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No. 1 V Yes certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be Other: Hospital: examiner? Residence 6 V Other: Scene Nursing Home 5 DOA ER/Outpatient 3 Inpatient this 1 Yes No After the 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day,Year) Certification: Natural Yes 2 No 1 Pending Funeral Director: Fnd 7/10/2007 Fnd 9:17 am 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
5322 Ski Jack Dr. Cambride MD 3 6 X Could not be Suicide determined (Specify) House Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Assistant Medical Examiner Ana Rubio MD. 2007

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 11, 2007

gistrar's Signatu

State Registrar

			1 - For State Registrar	State of Ma	aryland / Depa		of Healt			ene	23295
6 1	Physic	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Oscar Watson, J			, - · · · · · · ·			June	29 2007	1758 ^M
12	Exami	ner	4a. Facility Name (If not institution, give		_			tion of Death		4c. County of Death	
	<u> </u>	Je 4	Washington Advent 5. Social Security Number 6. S			If Under 1	akoma	Park	0.0	Montgomer	
18	Funeral Director			ex	e (In yrs. last birthday) 65 Yrs.		Days Hou		8. Date of Birth (Month, Day,		place (State or Foreign intry)
1			Usual Residence of Decedent			LL			Oct. 11	, 1941 Ark	ansas
	how		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	ctol	MD Prince (George's	Adelphi						1 ☐ Yes 2 📉 No
	or 28	Olre	10e. Street and Number			10f. Zip C			10	g. Citizen of What Cou	intry?
	ath w	ra	8416 20th Avenue				0783		1	USA	
	er de	by Funeral Director	Marital Status Never Married 2 Married	12. Was Decedent Armed Forces?		Was Decede If Yes, specif	nt of Hispanio y Cuban, Me:	ic Origin? (Spe xican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	irs aff	by F	3 ☐ Widowed 4 ☒ Divorced	1 ∐Yes 2⊠1 If Yes, Give Year or Dates:	40	1 ☐ Yes 2	₹No Spe	ecify:		Specify: D	lack
Ö	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show ta Madical Examinat number indiffed at	ted	15. Decedent's Eq	ucation		dent's Usual			1	6b. Kind of Business/h	
215	hin 7	ple	(Specify only highest gra	de completed) College (1-4or 5	life.	kind of work DO NOT use	done during retired)	most of workii	ng		•
2	or th	Completed	12th			ding H	Engine	er		Riggs Natio	onal Bank
nd	be file d oth	Be	17. Father's Name (First, Middle, Last)						(First, Middle, M	aiden Sumame)	
Maryland 21215-0036	Men	၉	Oscar Watson, Sr					earl Gi			
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural; or Items 23a or 28a-f show any injury or other traumetic event, the Medical Examination in Item Medical Examination at an Item 2016.		19a. Informant's Name/Relationship (7							City or Town, State, Zi	p Code)
e,	1 and Health	1	Saundra Harris/C	ompanion	20b. Place of Dispo	and department of the second	h Ave		Adelphi,		Town State
Baltimore,	Pages nent of I ant: If its ury or o		1 Burial 2 ☐ Cremation 3 ☐		cemetery, crer	natory or oth	er place)	1		Oc. Location - City or T	
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Ba	Depa Depa Impo any i		100	cohall.						rumeral no ngton, DC	20011
A STATE OF THE STA			23a. Part1 E ter the disease, or comp shock, or heart failure. List only	1-10-6-6						-	Approximate
	Physician		tmmediate Cause (Final	1 1					/		Interval Between Onset and Death
A	/Medical		disease or condition resulting in death)		e vo Scheri	hc c	aydio	ova sens	u a	iscare	
	Examiner				Setsy	2					
198		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	0					
	cuter	Examiner	that initiated events	C	Renal	10	cilor	C			
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence of):	,	inve				
8760	cate be executed physician and the burial-transit	dical	•	d	Resp	fai	fure				
9 ×		Physician/Med	IF FEMALE:	23c. tf yes, outcome	of programmy						
Box	eath certif attending for use as	lan	in the past 12 months?		2 Fetal death 3	Ectopic preg				23d. Date of deliv Month	ery Day Year
o	that the de ed by the a detached t	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	une or death 30	1 Other (spec	y)				
J.	The law requires that the tile has been signed by the bage 2 should be detached.	by Pi	Part II. Other significant conditions co	entributing to death be	ut not resulting in the ur	nderlying cau	se given in P	Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	w requires been sign should be	Q D							1 🗆 Yes	2 □ No 3 □ Pro	bably 4 \Unknown
000	aw re- s bee	Completed							24a. Was an	24b. Were auto	opsy findings available
¥	The lav	E O							autopsy	ed? prior to co	empletion of cause of
		Bec	25. Was case referred to medical				26. P	Place of Death	1 Yes 2		2□ No
<u>-</u>	Physician: rthis certifica ral director, p	ToE	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 🔀 Inpatie	nt 2 ER/Outpatien	t 3 DOA	T mu			ice 6 Other (Speci	fy)
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<u>0</u>	tendii eath. or: A the fu	catle	2 Accident investigation			М	1 ☐ Yes 2	2 🗆 No		4	
DIVISION OF	il or Attending F atter death. I Director: After d in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, stre (Specify)	eet, factory, o	office	2	8f. Location (Stre City or Town,	et and Number of Run State)	al Route Number,
	Hospital or Attending Physicien: 44 hours atler death. Funeral Director: After this certification in by the funeral director.		200 Contilion 457 C 111 -		, , , , , , , , , , , , , , , , , , , ,					1 1 1 1	
	Hospital 24 hours a Funeral letely filled	edical	29a. Certifier 1⊠ Certifying Phy (Chack Suly 2 Medical Examone)	iner. Un the basis of	of my knowledge, death examination and/or inv	occurred at restigation, in	the time, date my opinion,	te and place, a death occurre	nd due to the cau od at the time, dat	use(s) and manner as s e and place, and due t	stated. o the cause(s)
	To the Hos within 24 hi To the Fun completely	Med	29b. Signature and title of certifier	and manner sta	teu.		icense numb			d. Date signed (Month,	
	⊢ š ⊢ ŏ			MN				0100		07-02-	
1	2	-	30. Name and address of person who o	ompleted cause of de	eath (Item 23a) (Tuno	Print) S	(31	. /)	(1 4 - 1 1	B1156	2 0/
- (3)		TAHMINA K	AHME	O. Si	lver	ا کا در	1. U 10) V 1-4	MIN	BLVD & 2030	ast
34	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ur's Signature		7	U			
	Registr	ar	uu 0 5 2007	Ral A	· Doele						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2 July 10:30 A M 2007 Elmer L. Webster /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Min 1 ☑ M 2 ☐ F Yrs. 86 1920 North Carolina 245-12-6451 24, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 🛣 No Funeral Director Prince George's Oxon Hill 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20745 5014 Leland Drive 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced ss 1 and 2 should be filed within 72 hou of Health and Mental Hygiene. Item 27 is marked other than "natura other traumatic event, the Medical Es 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Navy Marine Transport Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter H. Webster Louise Sapp ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. 5014 Leland Drive, Oxon Hill, MD 20745 Ella Webster/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 ☐ Removal from State 7-06-2007 | Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 22. Name and Address of Facility Marshall's Funeral Home, 21. Signature of Funeral Service Licensee 20011 4217 9th Street NW, Washington, DC 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shockly of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bilateral Physician neumoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the sequentially list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the burial Physician/Medical as attending p for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by mbo lus Myo nan 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 Yes 2 NO certificate 2 NO Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical □ Medi Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 200 55120 2007 July 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) avenue SE Juite 310 Washington Richard Pahnen MD 1328 Southern 32. Registrar's Signature 31. Date filed-(Month, Day, Year) State 5 2007 Registrar

DHMH 17 Rev 1/2001

			For State	State of Maryland / Depa	artment of Health and I rtificate of Death		7001 50700
			Registrar Decedent's Name (First, Middle, Last		incate of Beatif	Rag. N	3. Time of Death
	Physici /Medic		Lucille	Walker		July 3	2007 7:25 AM
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death WICOMICO
	5		SALISBURY REHAB 5. Social Security Number 6. Se	& NURSING CENTER x 7. Age (In yrs. last birthday)	SALISBURY, M	8. Date of Birth	Birthplace (State or Foreign
	Funeral Director			M 200F Yrs.	Months Days Hours Min.		2) Country) Md
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryli -f eho	ţō	Md. Wicom	C-1-, L.			1∰Yes 2□No
	th the	Director	10e. Street and Number	- CO DUISION	10f. Zip Code	10g. (Citizen of What Country?
	ath wi	rai	606 Sevierway		21801	(1, S. A.
	iter de ritem	Funeral	11. Marital Status / 1 ▼Never Married 2 Married	Armed Forces? I	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Iteme 23s or 28s-f ehow ta Madical Ezanting must be incitified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 21 No Specify:		Specify: Black
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212	iene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	stic worker	T	tomemaking Industries
	be filed within 72 hours after death with the Marylan de Hygiene. Id Hygiene. Id other than "natural, or Iteme 23a or 28a-f show event, I're Marilcal Examinat must be indiffed at	Be C	17. Father's Name (First, Middle, Last)	UVV		me (First, Middle, Maid	
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other than sumatic event, I'm Ma	7	UNKNOWN	No. 11	mary	Emna	HNdrew
Mai			19a. Informant's Name/Relationship (T)	196. Mailir 505 A	ng Address (Street and Number of Ro	ural Houte Number, City	y or Town, State, Zip Code)
re,	s 1 and of Heelth item 27 other tr	,	20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	Date 2d	Location - City or Town, State
	nit. Pages artment of I ortant: If it injury or o		1. □Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	Removal from State	11 Comotay	H	ebrow, md
Ball	permit. Pages 1 and Department of Heelth Important: If Item 27 eny injury or other ti ance.	1	Service License	e de la companya della companya della companya de la companya della 2. Name and Address of Facility be UNIE Smith FUNERA 917 W. ISabelle	L Home	oury, maryland 2180/	
			23a. Part1. Extel the disease or comp shock, or least failure. List only of	lications that caused the death. Do not ent			Approximate Interval Between
	Physician		Immediate Cause (Final // disease or condition	· Colon C	Ruces		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
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	acuted and transit	Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.			
8760,	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	ai Ex	resulting in death) Last	Due to (or as a consequence of):			
687	ficate g phys	edicai		d			
Box	leath certific attending p I for use as i	M/us	230. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Dectopic pregnancy		23d. Date of delivery
O. E	it the dea by the all tached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Other (specify)		Month Day Year
, P.O.	res that the igned by be detact		-	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
of Vital Records,	quires en sign	ed by				1 ☐ Yes	2 → No 3 Probably 4 Unknown
9 9	e law requ has been je 2 should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a B	icete ha					performed? 1 ☐ Yes 2 ☐ 1	
V:E	Physicien: r this certifice ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatier	104	ath (Check only one) Home 5 ☐ Residence	e Cohar (Casala)
	ding Phy h. After this funeral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	it old box 4 le ituising i	28d. Describe how in	
siot	Attending or death. ector: After by the fune	catic	1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Tes 2 No		
	5 2 = -	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	281. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel of within 24 hours elected To the Funerel D completely filled in	Medical (29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knowledge, deatliner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the Within: To the comple	Me	29b. Signature and title of certifier	and mainty states.	29c. License number	29d. [Date signed (Month, Dey, Year)
	0		VINT !	They.	293	49	1/3/07
0	My		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, M.D. 200 CIVIC AVE	Print) SALISBURY, MD.	21804	, ,, , ,
	Sta Registr		31. Date filed (Month, Day, Year)	3 Registrar's Signature	calle)		

State

Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check one)

29b. Signature a

CHELZ. MARROLLS , MA MILS PORKULCE PIND, BOCKINGE, MO 32. Registrar's Signature 5 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

M.O.

25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D15236 29d. Date signed (Month, Day, Year)

1005 + 100t

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200^{Year} July 19 Day Physician Marie Barringer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Brightwood Lutherville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29, 19 15 Md -7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 F 220-07-4522 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f shoy other traumatic event, the Medical Examiner west be notified at Md. Harford Director Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 462 Crisfield Drive 21009 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 10 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental h is marked James L. Baroch Mary Uhlik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 sh Deparment of Health and Important: If Item 27 is in any in ury or other traum once. Emmitt J. Barringer Timonium Md. SOIL 204 Brightdale Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of July Date 23 20c. Location - City or Town, State cemetery, crematory or other place) Oak LAwn Cem. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 2007 22 Name and Address of Facility Connelly Funeral Home of Dun 2110 Collers Point Rd. 21222 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arter 10sclerate Cardiovascular dixeese **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Tany, leading to initial additional cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in PartI. β Completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Approximate Interval Between Onset and Death rces 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 2 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) DUIKNEMD/6565N. Charlostat

6:00 am

10d. Inside City Limits

21093

1 ☐ Yes 2X No

State Registrar

this certificate

within 24 hours after death To the Funeral Director: completely filled in by the

Hospital or

Be

Certification: To

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Hospital:

28a. Date of Injury (Month, Day Year)

32 Registrar's Signature

28b. Time of

		For	State of Mary		artment of Health and	Mental Hy	giene	UI	LUJUI
		State Registrar		Ce	rtificate of Death		Reg. No.		
Physici	an	Decedent's Name (First, Middle, Las	,		D1 .	2. Date of D Month	Day	Year	3. Time of Death
/Medic		Anna	Н.		Burke	July_		of Dooth	1:45AM™
Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or Location of Dea	atn	4c. County		orge's
age of the second	ă.	Southern Marylan 5. Social Security Number 6. Se		n yrs. last birthday	Clinton If Under 1 Year If Under 24 Hr	s. 8. Date of Bi	rth		0
Funeral Director	.		[™] 2√x 79	Yrs.	Months Days Hours Mir		1,1927	Virg	ace (State or Foreign ry) inia
land ow		10a. State 10b. County	10	c. City, Town or L	ocation			10	d. Inside City Limits
Mary -f sho	ţō	Maryland Prince Ge	orge's	C	linton				1 □Yes 2□No
r 28a	Director	10e. Street and Number	.01gc 5		10f. Zip Code		10g. Citizen of V		try?
h with	a D	8600 Mike Shapir	o Drive Apt	205	20735		U.S.A	•	
deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	0- 14. Race Blac	e - America k, White, e	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 ∏No If Yes, GiveXX Year or Dates:		1 ☐ Yes 2 ☐ No Specify:		Specify	Whi	te
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led w tygiel her ti		4th 17. Father's Name (First, Middle, Last)		HO	memaker	ame (First, Middle	e, Maiden Surnam	ne)	
ylallo Z	To Be	Will Alex	ander		Ber	tha	Feaul		
, Wallyla and 2 should satth and Men n 27 is marke ler traumatic		19a. Informant's Name/Relationship (Tarbara Dooms (Dat		1	ing Address <i>(Street and Number or i</i> Newburg Ct. Pas				
Pages 1 and of Height of H		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Hemoval from State		1 0	1y 20,	20c. Location -		
mit. Pages partment of portant: If it portant: If it y injury or ce.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen				2007			Maryland
permit. Departr Importa		De la la la la la la la la la la la la la	1	110000	633 Old Alexandr		al Home,		
		23a. Part1. Enter the disease, or com	plications that caused the	- 110				THEOT	Approximate Interval Between
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Or VILAI necolus, F.O. box of Physician: The law requires that the death certificate has been signed by the attending rail director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a condition of the contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contributing to death but not a contribution of the c	pregnancy Fetal death 3	DEctopic pregnancy Other (specify) underlying cause given in Part I. 26. Place of Dent 3 DOA Other: 4 Nursing of 28c. Injury at Work? M 1 Yes 2 No treet, factory, office	23e. Diction 1	I tobacco use cont Yes 2 No s an opsy formed? XX No r one) sidence 6 Other how injury occur (Street and Numbown, State)	te of deliverenth simple to the state of th	Day Year The cause of death?

State Registrar 3. Registrar's Signature

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hor Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natun any injury or other traumatic event, the Medical E one.

Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Bartimore,

Physician/Medical

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Completed

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Certification:

Medical

AVITED KHUNKHW

2007

31. Date filed (Month, Day, Year)

JUL 2 0

MO 32 Registrar's Signature

ed by the attending physician detached for use as the buria peen Sec this After

The law requires that the death certificate be executed and Attending Physician: completely filled in by the funeral director, after death 0 To the Hospital within 24 hours a To the Funeral C Hospital

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to edical examiner? 1 ☐ Yes 2 ☐ Mo 27. Manner of Death 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 0 0 0 6 3 4 3 0 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

mare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVITED KHUNCHU MD 2401 WEST BELVEDERE BALTIMORE MD 21215

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 0555 Phyllis Arbedean Conway July 18, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 915 Armistead Way Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Month, Day, Year, Day, Yea 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1□M 2√F 213-24-5301 MD 77 08/09/1929 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show r 28a-f show notified at 1 ☐Yes 2 ☐ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or ? r must be r 915 Armistead Way 21205 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If then 27 is marked other then any Injury or other traumarked. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 'natural', or items dical Examiner mu 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White <u>م</u> 3 ☐ Widowed 4 🔀 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred McDonald ည Mary Lumms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 915 Armistead Way, Baltimore, Mary F. Cave / Daughter MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowrdge Mem. Park 07/21/2007 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA ral service icensee 21. Signature M01452 2818 E. Baltimore ST., Baltimore, MD 21224 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE DISEASE Physician CHRONIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 4□ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Munknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16619 20,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOWARE DR. BALTIMORE MD. 21236 C.VERGARA-SOARES 9940 FRANKLIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

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Lillian Coffren

			1 – For Registrar	State of Ma	aryland		artmer <i>rtificat</i>			nd Me		giene Reg. No.	2007	23	305
			Decedent's Name (First, Middle, Las	t)							2. Date of Dea	ath			of Death
	Physici		Arlean			Cop	0000	0.			Month	Day	200		I PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of		oug	4c.	County of De		
			The Johns Hopki 5. Social Security Number 6. Se		ital	st birthday)	Bal	timo	re C	ity 4 Hrs/	8. Date of Birt	h	NA	rthplace (State	or Foreign
	Funeral Director			M 2√2 F / A9		Yrs.	Months	Days	Hours	Min.	(Month, Day	y, Year)	3. 6	ountry)	_
			Usual Residence of Decedent	21	82						9–3–1	924		N.C	•
	iand ow		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limits
	Mary Feb	ō	Md. NA	A		Ba	ltimo	re						1 🔯 Y	es 2 □ No
	179 the	Director	10e. Street and Number				10f. Zij	Code				10g. Citiz	en of What C	Country?	
	a or	۵	2426 E. Lanvale	Street				212	13				USA		
	ns 2	by Funerai	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V	Was Dece	dent of His	spanic Origi	in? (Spec	ify Yes or No	- 1	4. Race - Arr	encan Indian,	
·0	ter of	Ē	1 ☐ Never Married 2 ☐ Married	Amed Forces? 1 ☐ Yes 2 ☐ ! If Yes, Give \(\)		'	f Yes, spe	city Cubai	n, Mexican,	Puerto F	lican, etc.)	-	Black, Wh		
ဗ္ဗ	urs a	þ	3√2 Widowed 4 □ Divorced	If Yes, Give ∆ Year or Dates:			1 🗆 Yes	X J №	Specify:				Specify:	Black	
9	within 72 hours after death with the Maryland ene. Itan "ratural", or Items 23a or 28e-f ehow Ita Nadical Exantinar must be notified at	Completed	15. Decedent's Ed	ucation		16a. Deced	dent's Usu	ai Occupa	ition	af wadda	_	16b. Kir	nd of Busines	s/Industry	
2	Pin 7	ple	(Specify only highest gra	College (1-4 or 5	5+)	life. l	DO NOT	se retired)	luring most (OF WORKIN	g				
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g	e filed al Hygi l other vent, I	Be (17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle,	Maiden .	Sumame)		
<u>a</u>	should be nd Mental marked o	٦ 1	Mose		Eva	ns			Vio]	la			Dal	.e	
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I feath and Mental Hygiene them 23a or 28a-f show other traumatic event, I'm Madical Examinations invitilled at		19a. Informant's Name/Relationship (7	урө, Print)		19b. Mailir	ng Address	(Street a	nd Number	or Rural	Route Numbe	er, City or	Town, State,	Zip Code)	
	and and and and and and and and and and		Annie Coppage	Dau	ghter				vale S	Stree	et , Ba	ltim	ore, M	d. 21	213
Š	permit. Pages 1 an Department of Heat Important: if itam 2 any injury or other once.		20a. Method of Disposition	Domewal from State	20b. Pla	ace of Dispo metery, crer	sition (Na	me of other place	9)	Da	ate	20c. Lo	cation - City of	r Town, State	
Ĕ	Pages nent of I int: If it iry or o		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Mt	. Carı	mel C	em.		7–21-	-07	Dun	dalk,	Md.	
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service Licen	S88		22	2. Name a	nd Addres	s of Facility	Ma	arch F.				
m	Depa Impo any ir		& lady	Wa	ne_		1101	E. N	orth A		, Balti			21202	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death.								,	Approxin	nate
	Physician		Immediate Cause (Final	a Chroni		back	1.10%	21100	a.20.c.l	Nie	0000			Onset an	d Death
1	/Medical		disease or condition resulting in death)	Due to (or as	a conseque	ence of):	nvei	UIIII	oriarg	<i>U</i> 13	ease			15 year	175
	Examiner			Pulma	naril	HUS	pert	PNSI	N/A					1040	ars
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	ence of):	CIII							1010	
\checkmark	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	•											
oʻ	exection and and and and and and and and and an	Exe	resulting in death) Last	Due to (or as	a conseque	ence of):									
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9	tifica og ph as th		1-2												
ŏ	n cer endir use	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic p	rognanov				2	3d. Date of d		
m	deat e att	icia	in the past 12 months?	4☐Pregnant at			Other (s						Month	Day	Year
ö	that the death certific ed by the attending p detached for use as	hys	9 □ Unknown	9LI UNKNOWN											
Division of Vital Records, P.O. Box	signed be det	by Physician/Me	Part II. Other significant conditions of	ontributing to death b	ut not resul	Iting in the u	nderlying	cause give	n in Part I.		23e. Did to	obacco u	se contribute	to the cause of	of death?
ğ	w require been sig should b	ed	Hypertension								101	es 2	ZNo 3□F	Probably 4	□Unknown
ပ္ပ	s be(Completed	,								24a. Was		24b. Were	autopsy findin	gs available
æ	The tends age (E										rmed?	l death?	s 2 No	or cause of
<u>a</u>	fiffica for, p	a	25. Was case referred to medical						26 Place o	of Death	(Check only o		1016	20140	
>	ysicl s cer direc	0.0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆 E	R/Outpatier	nt 3 D	Othe	r		ne 5 ☐ Resid		Other (Sp	ecify)	
0	er th	<u>-</u>	27. Manner of Death	28a. Date of Inju (Month, Da	iry :	28b. Time of	f	28c. Injury Work			8d. Describe l			,,	
<u>0</u>	ath. Fr: Att	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		y rear/	Injury	М		r Yes 2 □ N	lo					
<u>Vis</u>	Atte	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place of inj	ury - At hor	ne, farm, str	reet, factor	y, office		2	8f. Location (5			Rural Route N	umber,
ā	s afte s afte s afte od in	Certification: To	- I Homicoe	building, et	o. (Specify)	,					City or Tov	···, Jiaie)			
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Ph	ysician: To the best niner: On the basis o	of my know	vledge, death	h occurred	at the tim	e, date and	place, a	nd due to the	cause(s)	and manner a	as stated.	e(s)
	the F the F the F	Medical	one)	and manner st	ated.						-				- 188
	To To	2	29b. Signature and title of certifier	0	5 - V 1			c. License		_		29d. Date	signed (Moi	nth, Day, Year	7
,	,		Blyan Starte	1 "	esid	tins	1	ne S	-00	U		7 (/	-4 14	SIC C) <i>†</i>
	5		30. Name and address of person who	completed cause of c	leath (Item	23а) (Туре,	Print)	rnil		16.0	L. 10 W		Δ8. i	1 1	207
	2		Benzemin Steinbe	ad John	Hop Kil	N HON	JAME,	N DO	ath w	01.45	inect, Ball	TIMBLE	Maryk	md di	00 t
	Sta Registi		31. Date filed (Month Day 2 eax) 20	07 3th Registr	ar's Signati	иге 40									

	1 - State Registrar		(Certificate of	Death		g. No.	07 2330
ian	1. Decedent's Name (First, Middle, L	Last)				Date of Death Month	h Day	3. Time of Dea
cal	Janice Dexter			1 a on T	1 6 (D H	July	17, 200	
ner	4a. Facility Name (If not institution, g 5028 Westpath		er)		r Location of Death thesda	1	,	gomery
		. Sex 7.	Age (In yrs. last birth	1000	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Fo Country)
	216-46-3026	1 □ M 2 🙀 F	98 ^Y	rs. Monais Bayo	Tiodio iviii.	May 2,		Rhode Islan
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Li
ţo	 Maryland Montgo	omery	Beth	esda				1 ☐ Yes 2½
Directo	10e. Street and Number			10f. Zip Code		10	0g. Citizen of W	/hat Country?
	5028 Westpath Te			20816				States
Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decede Armed Force 1 ☐ Yes 2	es?	 Was Decedent of H If Yes, specity Cub 	an, Mexican, Puerl	pecity Yes or No- o Rican, etc.)		e - American Indian, k, White, etc.
by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 ☑ No	Specify:		Specify	White
	15. Decedent's (Specify only highest to	Education grade completed)		Decedent's Usual Occu Give kind of work done	during most of wor		16b. Kind of Bu	siness/Industry
Completed	Elementary/Secondary (0-12)	College (1-4	i	life. DO NOT use retire Homemaker	d)		Own I	Home
e Co	17. Father's Name (First, Middle, La			nomemaker	18. Mother's Nar	ne (First, Middle, M		
o B	Elmer E. Grinne	·11			Mabel	D. Almy		
-	19a. Informant's Name/Relationship		19b.	Mailing Address (Street	and Number or Ru	ıral Route Number,	City or Town,	State, Zip Code)
	Richard W. Chace	e / Grands			Terrace			yland 20816
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from St	comoton	Disposition (Name of crematory or other pla	July	7 23,		City or Town, State
	4 Donation 5 Other (Spe		Hillsid	le Cemetery				, Rhode Isla y Funeral Ho
	21. Signatury of Funeral Service Lic	Cerisee	M01473	Bethesda-C Bethesda,	hevy Cha	se Inc.	7557 T	Visconsin Av
	23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cau						Approximate
								Interval Between
	Immediate Cause (Final disease or condition			cular Accid				Interval Between
	Immediate Cause (Final	a. C		cular Accid				Interval Betwee Onset and Dea
ė,	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	Cerebrovas as a consequence of	cular Accid				Interval Betwee Onset and Dea
miner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Each of the cause (Disease or injury)	a. Due to (or	Cerebrovas	cular Accid				Interval Betwee Onset and Dea
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Division or Vital Becords P.O. Box 68760

29c. License number

D44157

July 17, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ira Berger, M.D. 1201 Seven Locks Road #111, Rockville, Maryland 20854

State Registrar

		For Amend Item 2 - State Registrar		τυ. , ξ	3009,07	rtifica	te of l	Death				001	20307	
Physicia /Medica		1. Decedent's Name (First, Middle, Las Antonina Cate		sett						July 1		.007 Year	3. Time of Death 6:25 A	
Examine	er :	4a. Facility Name (If not institution, give 100 Rutland Cour)			LaP1a				4c. County of Death Charles			
Funeral Director		5. Social Security Number 6. Sec. 577 46 4082	7. A	ge (In yrs. 73	last birthday) Yrs.	Month:	er 1 Year s Days	If Under 24 Hours	Min.	Date of Birt (Month, Day Sept 2	v, Year)	Co	thplace (State or Foreignintry) ashington D	
f show	ō	10a. State 10b. County Maryland Charles		10c. Cit	y, Town or Lo								10d. Inside City Limit	
Se or 28s	Direc	10e. Street and Number 100 Rutland Cou	ırt			10f. Z	ip Code 20646				-	zen of What Co	•	
I, or items 2; xaminer mus	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 20 If Yes, Give Year or Dates:	?		If Yes, sp	edent of Hi ecify Cuba	spanic Origin n, Mexican, F Specify:	n? (Specif Puerto Ric	fy Yes or No- can, etc.)	,	14. Race - Ame Black, Whit		
ical I	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	5+)	16a. Dece (Give life. Homer	kind of w DO NOT	vork done d use retired	lurina most o	of working	1		nd of Business		
h and Mental Hyglene. 7 Is marked other than "r reumatic event, the Mad	To Be Co	17. Father's Name (First, Middle, Last) Orazio Clatto			Homer	narco		_		First, Middle, Sente	Maiden	Sumame)	ie	
27 Is mar r treumat		19a. Informant's Name/Relationship (7 Catherine French		·)						Route Numbe		r Town, State, 2	Zip Code)	
Department of Health a Important: If item 27 is any injury or other tre once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		, '	Place of Disponentery, crea	matory or	other place		20, Dat	2007		cation - City or		
Uepartn Imports any inju		21. Signature of Fune ral service Licen	l maaas	7	22	2. Name	and Addres	s of Facility		Funera d, Cli			6633 01d 20735	
ysician Medical aminer		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	aDue to (or as	ine.	null uence of):								Approximate Interval Between Onsol and Death	
in and ial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as											
ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	Ectopic Other (pregnancy specify)					23d. Date of del Month	livery Day Year	
eugi p eq	à	Part II. Other significant conditions co	entributing to death I	out not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to			o the cause of death?	
page 2 should	Completed								-	24a. Was autop perio 1 Yes		prior to death?	utopsy findings availal completion of cause o	
certifi	Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 No	Hospital:	- 5			Othe			Check only o				
unera	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 [] Inpati 28a. Date of Inj (Month, Da		28b. Time o Injury		28c. Injury Work		28	d. Describe h		3 □Other (Spe y occurred	icity)	
within 24 hours after death. To the Funerel Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At hi tc. (Specif	ome, farm, str	reet, facto	ory, office		28	f. Location (S City or Tox			ural Route Number,	
ne Funeral	edicai	29a. Certifier (Check of 1) Certifying Phyone) 2 Medical Example 1	ysician: To the best iner: On the basis of and manner s	of examina	wledge, deat ition and/or in	h occurre vestigation	od at the tim on, in my op	e, date and pointion, death	place, and occurred	d due to the at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)	
TEO S	Σ	29b. Signature and attended certifier	1			2	9c. License	number			29d. Dat	e signed (Mont	h, Day, Year)	
5 - 0			Aa.				*	6419			Same?	1-11	-2-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE 9. Birthplace (State or Foreign 5. Social Security Number Age **Funeral** 1965 Mary 1□M 212 F 218-64-1219 Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 2121 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 Is marked other than "natu traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) doughter) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 2/22 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 19/2007 1

Burial 2 □ Cremation 3 Removal from State Star 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
10 Seph L. Rus
2222 W. North 21. Signature of Funeral Service Licensee Fungral Ave. Ba Approximate Interval Between Onset and Death 23a. Part /Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) ~44rs **Physician** /Medical Due to or as a consequence of): Cancer Examiner reast if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 □ Yes 2 2 No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has le 2 autopsy After this certificate har funeral director, page perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 ther (Specify) 20 No Hospital: 1 Yes 2 ER/Outpatient 3 DOA P 1 Inpatient Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director; completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Tomison 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Katharine Hamson Richer Hospica N. EUTAN ST. BOITO MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			, For	•	artment of Health and M	lental Hygien	ie	
	_		State Registrar	Ce	rtificate of Death	Reg. N	lo. 2007	23309
	Physicia	en	1. Decedent's Name (First, Middle, Last)	7		2. Date of Death Month	ay Year	3. Time of Death
aig _e	/Medic	al	Dorothy	DIXON		July 15	200 7	4:30 PM
0	Examin	er	4a. Facility Name (If not institution, give str	· i/	4b. City, Town, or Location of Death	2	A //	1
	##-		5. Social Security Number 6. Sex	Sing Itome	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthpl	ace (State or Foreign
н	Funeral Director			1 2 F 92 Yrs.	Months Days Hours Min.	Fo.b. IS 19	714 Na	Fuland
	D	1	Usual Residence of Decedent					of lastide City Limits
	irylan show 1 at	_	10a. State 10b. County	10c. City, Town or L	ocation		10	od. Inside City Limits 1 X Yes 2 □ No
	Ba-f s	Director	MICH NA	Balti	more	140- (Citizen of What Coun	
	with the	ă	10e. Street and Number	+	10f. Zip Code	109. (uy:
	eath ns 23 must	eral	11. Marital Status	. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	
'	r iten iner	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rićan, etc.)	Black, White,	etc.
930	be filed within 72 hours after death with the Maryland tal Hygiene. de Hygiene. do dher than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	3 Widowed 4 □ Divorced	If Yes, Give / Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: B	ack _
2-0	72 hc 'natu dical	Completed	15. Decedent's Educa (Specify only highest grade of	completed) (Giv	edent's Usual Occupation e kind of work done during most of work		Kind of Business/Inc	lustry
121	vithin ene. than '	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	,	Damos	stic
2	filled \ Hygie ther t	ပ္သ	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maid	len Surname)	2110
Maryland 21215-0036	ld be ental ked o	To Be	Henry Bar	nes	1/11/1	an D	ixon	
ary	shou and M s mar umat		19a. Informant's Name/Relationship (Type	Print daughter 196. Mai	ling Address (Street and Number or Rui	al Route Number, Cit	y or Town, State, Zip	Code)
	and 2 salth a 27 is er tra	1	Mrs. Bernice.	Jackson 26	68 OSWEGO A	ve. Ba	Ito. Ma	,21215
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Disp cemetery, cr	position (Name of ematory or other place)	Date 20c.	Location - City or To	11 11 1
ij	Pag ment tant: I		4 Donation 5 Dother (Specify)	Iring	y Cemetery /20	12007 I)undali	R, Ma.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		21. Sign the of Funeral Service Licenses	4 Dun 1	oseph L, Russ F	ineral t	tome, P.A	211
	462 60		23a Part V Enter the disease or complice	ations that caused the death. Do not e	nter the mode of dving, such as cardiac	or respiratory arrest.	. Ma. 21	Approximate
		N 18	23a. Part1 Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	tic Cardianasei	Dan de	. 0.	Interval Between Onset and Death
).	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	que caracina de	car us	cure	Years
	Examiner		b					
0	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
No	ecute and I-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
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687	ificate y phys is the	edical	a.					
Вох	n cert anding use a	II/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 3	□Ectopic pregnancy		23d. Date of delive	
	that the death certificated by the attending posteroed for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		Other (specify)		Month	Day Year
P.0	at the	Phy	9 ☐ Unknown Part II. Other significant conditions cont		underlying cause given in Part I	23e Did toham	co use contribute to the	ne cause of death?
	a Dec		Weman seed		enipausal	1 ☐ Yes		pably 4 ☐ Unknown
or Vital Records,	w requir been si should I	Completed by	Varance days	4.5	Alex Glass	24a. Was an	24h Wara auto	psy findings available
Rec	e far has je 2	ldm	varentar anne	Mas		autopsy performed	prior to co death?	mpletion of cause of
<u>a</u>			25. Was case referred to medical		26 Place of Pea	1 Yes 2 1 th (Check only one)	√No 1 □ Yes	2 No
Š	Physician: this certific	To Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Othor	ome 5 Residence	e 6 □Other (Specia	'y)
100			27. Manne Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe how in		
sior	Attendlr death. ctor: Af y the fur	atio	2 ☐ Accident investigation		M 1 Yes 2 No			_
Division	or Att fter de Direct in by 1	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, S	t and Number or Run tate)	al Route Number,
	pital ours al eral □		29a. Certifier 1 Certifying Physi	iclan: To the best of my knowledge, de	ath occurred at the time, date and place	and due to the caus	e(s) and manner as s	stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only one) (Check only one)	er: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	irred at the time, date	and place, and due t	o the cause(s)
	vithin To th	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year)
			17 Volabelle Va	egreges 079	013657	Jo	uly 16,2	7007
	^		30. Name and address of person who cor	npleted cause of death (Item 23a) (Typ	e, Print)	0.4	Mad 4 14	/ /
	7			REGOR, 700 W-	e, Print) 40 % Street, Be	refielde	1 100 212	-1/
	Sta Regist		31. Date filed (Month, Day, Year)	Hegistrar's Signature	all			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4:30 A.M 2007 MENIC Juh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CONKLING South DALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **™** M 2□ F 84 235-24-0004 Director ITALY Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Show r 28a-f show notified at 1 Yes 2 No BAltimore Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be South USA. 210 PNKLING 21224 Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Yes 2 No ALMY
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steelworker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MICHALL occo Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21224 Department of Health a Important: If item 27 is any injury or other training. STREET CONKLING BALTO MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GARdens of Faith Cen July 23, 2007 BA HIMORE MARYLAND 4 Donation 5 Other (Specify) Entombyest 22. Name and Address of Facility 105 EPH N. ZANNINO JR. 263 S. CONKLING Street 21. Signature of Puneral Service Pe FUNCARE BAIto Approximate Interval Between Onset and Death Part I. Enter the disease, shock, or heart failure. Li implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** Intricular Sudden /Medical Due to (or as a consequence of): **Examiner** typh tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation Injury ours after death.

neral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 671 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

B.K

HIEPEMICK 31. Date filed (Month, Day, Year) 10

32. Registrar's Signature

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	1 - State Registrar 1. Decedent's Name (First, Middle, Las	State of Maryla	•	rtificate of			g. No.	07	3. Time of Death	
sician edical	George		Eaddy			Month 2	Day 12	Year 07	3.08/	
eral	4a. Facility Name (If not institution, give Franklin 59 u.c.) 5. Social Security Number 6. S 247-72-7677	ue Hospita	vrs. last birthday) Yrs.	Rosea		If Under 24 Hrs. 8. Date of Birth		4c. County of Death Baltin More 9. Birthplace (State or For Country)		
	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	ocation		4-12-19	942		d. Inside City Limi	
Director	Md. NA	1	Baltin	nore		10	10g. Citizen of What Country?			
any injury or outer traditions event, the medical raditions the notice at once. To Be Completed by Funeral Director	6026 Framingham 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Road 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		212 Was Decedent of H If Yes, specify Cuba	06 lispanic Origin? (Sp an, Mexican, Puerto <i>Specity:</i>	ecify Yes or No- Rican, etc.)	14. Ra	ISA ce - America ick, White, e	tc.	
Completed t	15. Decedent's Ed (Specify only highest gra	lucation	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of work	ing 1	6b. Kind of E	Business/Ind	ustry	
Be Con	10th grade 17. Father's Name (First, Middle, Last)	Cor	Construction 18. Mother's Name ((First, Middle, Maiden Surname)				
To	Emmett 19a. Informant's Name/Relationship (7)	Eac Type. Print)		ng Address (Street	Lydia and Number or Run	TOUN al Route Number,			<u>Faddy</u> ^{Code)}	
al Examiner	G .									
leted by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	⊒Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day Yea		
ed by Pi	Part II. Other significant conditions of	ontributing to death but not i	underlying cause given in Part I. 23e. Did to			obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknow				
Somp						24a. Was an autopsy perform 1 Yes 2	·	prior to com death?	sy findings availa pletion of cause o 2 No	
To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	FR/Outpatier	ot 3 DOA Oth	or.		(Check only one)			
Medical Certification: To	1 Impatient 25/2HV/Outpatient 3 DOA 4 Nursing Home 5 Residence 6							rred		
SalC	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the til	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and rite and place	nanner as sta , and due to	ated. the cause(s)	
	29b. Signature and title of certifier			29c. Licens			d. Date sign			
Medical	195-	E. Guon	jian	D62	.019 Square I		7-1	2-0	07	

			State Registrar	iviai yiai iu / i		rtificate of L			eg. No.)7	3. Time of Death	
	Physicia	an	Decedent's Name (First, Middle, Last)	_				Month	Day	Year	M	
/Medical			Mary	G.		Eaton 4b. City, Town, or	Location of Doct	7	2 200 4c. County o		6:15a [™]	
	Examin	er	4a. Facility Name (If not institution, give street and num 1304 Kenhill Ave.	ber)		Baltin	nore		NA			
	Funeral Director		5. Social Security Number 219–28–0104 Usual Residence of Decedent	7. Age (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, Year)	9. Birthpli Count	ace (State or Foreign ry) Va	
	ryland how at		10a. State 10b. County	10c. City, Tow	vn or Lo	cation				10	od. Inside City Limits	
	a-f s	cto	Md. NA		Bal	timore					1 ☐ Yes 2 ☐ No	
	ith th or 28	Director	10e. Street and Number			10f. Zip Code	_	1	0g. Citizen of W		try?	
	23a ust b	la I	1304 Kenhill Ave.			2121			USA			
2	be filed within 72 hours after death with the Maryland Hylygiene. d other than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Dece. Armed For 1 □ Yes If Yes, Giv	² ₩ No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√ No	ispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race Black Specify:	- America , White, e Bla	etc.	
5	2 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a	a. Deced	dent's Usual Occup	ation	rkina	16b. Kind of Bus	iness/Ind	ustry	
<u>,</u>	thin 7 e. an "n Medi	Completed	Elementary/Secondary (0-12) College (1-	4or 5+)	life.	kind of work done of DO NOT use retired	i)	King				
1	ad wi	Con	7th grade NA	F	lous	ewife	40. 14-15-1-15		Own Hor			
2	be fill d oth d oth even	Be	17. Father's Name (First, Middle, Last)	Marks			Mati]	me (First, Middle, .	Bradle			
2	2 should and Men is marke aumatic	မ	Robert		te Mailie	ng Address (Street					Codol	
3	12 sh h and 7 is π traum		19a. Informant's Name/Relationship (Type. Print) Plummer Easton, Jr.	Son		8 W. Fair					21223	
5	1 and Health em 27 ther tr		20a. Method of Disposition			osition (Name of matory or other place		Date	20c. Location - 0			
5	Pages nent of h int: If ite		1 Bunal 2 □Cremation 3 □ Removal from 5	otate		matory or other place Mem. Pk.	7-6-	-07	Arbutus	, Md.		
	permit. Pages 1 and 2 should be filed within Department of Headth and Mental Hygene. Important: If item 27 is marked other than any injury or other fraumatic event, the Meany injury or other fraumatic events.		21. Signature of Funeral Service Licensee	7	22	2. Name and Addres		March F.	H. East		L202	
	20240	_	23a. Part1. Eprer the disease, or complications that conshock, or heart failure. List only one cause on each	used the death. Do		101 E. No				. 2.	Approximate Interval Between	
	Physician /Medical Examiner		shock or heart failure. List only one cause on earning in disease or condition resulting in death) a. Due to (or as a consequence	m	idive de	me Di	Slasi			Onset and Death	
5	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence	s a consequence of): A Turbs s a consequence of): A heral Vascular Disease							
	ifficate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last Due to (or as a consequence): (Vascul	on Dise	ease				
O. DOA 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the post 12 months?	come pf pregnancy irth 2 Fetal deat ant at time of death own		_Ectopic pregnancy	/		23d. Date Mor		Pry Day Year	
. L (2)	uires that t signed by Id be detac	δ	Part II. Other significant conditions contributing to decam part to conditioning in the discontinuous great in the conditions great in the conditions great in the conditions great in the conditions great in the conditions great in the conditions great in the conditions great in the conditions great great in the conditions great							tobacco use contribute to the cause of death Yes 2 \(\square\) No 3 \(\square\) Probably 4 \(\square\) Unkr		
	he law req e has beer age 2 shou	Completed						24a. Was a autop perfo 1□ Yes	sy p rmed? d	rior to cor eath?	psy findings available npletion of cause of	
2	an: T	Be C	25. Was case referred to medical				26. Place of De	ath (Check only o	/-			
>	ysici is cer direc	To B	examiner:	npatient 2 ER/C	Outpatie	nt 3□ DOA Oth	er: 4 \(\sum \) Nursing I	Home 5 Resid	lence 6 Othe	er (Specif	y)	
ding Phy	nding Ph th. r: After th e funeral		27. Manner of Death 1 X Natural 5 Pending (Mont) 2 Accident investigation		28c. Injury at Work? 1 Yes 2 No							
בואום	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						Street and Numbern, State)	er or Rura	l Route Number,	
	e Hospita 24 hours e Funera etely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manifest a	best of my knowledgasis of examination and exa	ge, deat and/or ir	th occurred at the tinvestigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place, a	nner as s and due to	tated. o the cause(s)	
	Nithin Nithin To the	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed		Day, Year)	
			> Alulus.)	35082		7/18	107		
	3		30. Name and address of person who completed caus	e of death (Item 23a	(Type	Print) Bal	limore	1mD	2/22	f		
	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 0 2007	egistrar's Signature	A	radio			-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 10:42 A^M July 17, 2007 Mary Lou Fowler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M VT Director 98 Feb 3, 1909 009 12 0566 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 ☐ Yes 2 🕅 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified a once. Prince George's Upper Marlboro Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 7103 Sugrue Court United States Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📆 🏌 o White \$ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Entre Business Owner Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Sweeny Martha Talbot 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7103 Sugrue Court, Upper Marlboro, MD 20772 Jane McKinley (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee Crematory July 19, 2007 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 21. Signal unu al S 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician COROMANY SYNDROME ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day in the past 12 mont 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown MATC IS D eted 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No DESPINATURY ACIDUCIS 24a. Was an Comple autopsy performe 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 🏖 No 1 Inpatient ≥DER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 De Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,⁴ or Attending Physician;

attending physician and for use as the burial-tran

28a-f show

Baltimore, Maryland 21215-0036

been signed by the s certificate has been rector, page 2 shoul within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir the

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

K Makeyin

MD.

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

D50689

0711812007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHILK MAHA) and MD

CENTER 7503 SYRRPTTS RD- CLINTUN MD 2073 HUSPITAL

SUNTHERN MARYLAND 31. Date filed (Month, Day, Year) JUL 2 2007 0



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryands Department of Medical And Wental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 108 2007 trancis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Raltumere City

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Baltimore Sinai 28 Hosvital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 584.65.3720 1 □ M 2 🛛 F **Director** Irinidad Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 5501 Wesley Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examines 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Health Care 18. Mother's Name (First, Middle, Maiden Surname) นัก Ln ณฑ 17. Father's Name (First, Middle, Last) To Be Shaffick Khan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) licholas Samarou 20b. Place of Disposition (Name of cemetery, crematory or other place) baltimore mo 21207 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/23/07 Bartimore MD oilly Vaugha C. Greene Runnal Service 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Ad Mandallstain MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wk /Medical Due to (or s a consequence of): Examiner Teningitis Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Box 68760€ Coronary ician and burial-tran The law requires that the death certificate be execu Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9∏Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 4 Monknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 med 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paltimore Hospital Brandon ogioka

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 2 0 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decement's Name (First, Middle) 2. Date of Death **Physician** green /Medical Examiner street and number, 4b. City. Town, or Location of Death County of Death Baltimore owson If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday)

G 7

Yrs. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 929 1 ☐ M 2 😿 F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director anda Baltimore town 10e. Street and Momber 10f. Zip Code 10g. Citizen of What Country? 2 40 20 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2XNo Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry dary (0-12) College (1-4or 5+) tician 17. Father's Name (First, 18. Mother's Name (First, Middle, Maiden Surname, Be Middle. nens ပ 19a, Informant's Name/Relationship City or Town, State, Zip Code) 21133 Method of Disposition 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Concer Physician monters /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 □ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 🔼 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 10 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 211 No Other: 1 Yes P 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) pile this Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Tyes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOZINOT 670i VCHALLES 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 7:04 P.M Nellie Green 07 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE RALTIMORE HOSPITAL GOOD SAMARITAN 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1□M 2√F 75 220-20-6804 2-27-1932 Md. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ¥7 Yes 2 ☐ No Director Baltimore Md. NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21218 835 Belgian Avenue Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unemployed llth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Parker Josefus ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3042 Stafford Street, Baltimore, Md. Cassandra Williams Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriał 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7-23-07 Randallstown, Md. King Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pesterion Acute **Physician** /Medical Due to (or as a consequence of) Examiner pertencion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Mellit iabetes burial-tra Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ☐ Yes 2 ☐ No 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 212 No 3□ DOA 1 ☐ Yes 2 ER/Outpatient Medical Certification: To Division or this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

REEN

GREEN

Good Samaritan Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Deep Sharma, PGY-2

31. Date filed (Month, Day, Year)

RESODO

07

Ballimore

07-05163

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ennifer Gill	1-	St For State	tate of Maryland	/ Depar	tment i	of Health ar o <i>f Death</i>	id Mental H		. 2	007 233
Physician/	Re	eqistrar Decedent's Name (First, Midd	ile,Last)	- Certi	neate	or Death		2. Date of Death		3. Time of Death
Medical Examiner		Jennifer Le	e Gill					July 6, 200		02 19 nrs
()	4	Jenni fer Le a. Facility Name (if not institution Greater Baltimore Me		r)		4b. City, Town, o	Location of Death	4c. County of Death Baltimore County		
Funeral	. 5	Social Security Number		ge (In yrs. las	t birthday)		ar If Under 24Hrs	. 8. Date of Birth		g. Birthplace (State or
Funeral Director	None 1 M 2 XF Yrs. Months Days H							06/11/		Maryland
any paceparative and a second	_	Sual Residence of Decedent Oa. State 10b. County		10c. City, T	own or Lo	cation				10d. Inside City Limit
\$		MD Balt	imore		Tir	monium	7.72	147		1 Yes 2 X
the Maryland or 28a-f show lifted at once. Director	1	0e. Street and Number				.10f. Zip Code		10	g. Citizen of Wh	
h the l		824 Branford		T ₁		21093				States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1	Marital Status XNever Married 2 N	Married 12. Was Deceder Armed Forces 1 Yes 2			Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto		White	- American Indian, Black, e, etc.
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0036 within 72 hour giene. her than "natu t. Medical Exau		0	, conege (1-4 or		De	ependent		V	Not :	Self Supporti
21215-0036 21215-0036 and be filed within 7 Mental Hygiene. marked other than ic event, the Medica To Be Comple	1	7. Father's Name (First, Middle					18.Mother's Nam	e (First, Middle, M	laiden Surname)
121 1 be fill ental H arked vent,		Stephen Craig			401 14-	illian Address (Ota	Lisa L		har City of Toy	n, State, Zip Code)
D 21 should and Me 7 is ma natic er	2	9a. Informant's Name/Relation Stephen C. Gi				Branford		-		
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Baltimore, MD cemit. Pages I and 2 sho pepartment of Health and important: If item 27 is njury or other traumati	-	1 X Burial 2 Crematic		State Dula	aney V	rother place) alley Memor	and the same of the same			
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	+	23a. Part I. Enter the disease, of			Do not ent	er the mode of dyin	g, such as cardiac	or réspiratory arre	est, shock, or he	e, MD 21061 Part Approximate Interv
Physician Medical		failure. List only one caus	e on each line.							Between Onset an Death
aminer		Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a cor							
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	2	F FEMALE: 3b. Was decedent pregnant in	23c. If yes, outo	come of pregr	ancy	Fetal death	Ectopic pregr	nancy	23d. Date of Month	f delivery Day Year
30x 6876/ death certificate e attending phy for use as the b	5	past 12 months?	4 Pregnant	at time of dea	2 ath 5	Other (Specify)	Zatopio piragi			•
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ires that the de signed by the detached for the Phy		Part II. Other significant cond	litions contributing to de	ath but not re	sulting in t	he underlying caus	e given in Paπ i.			Probably 4 Unknow
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Records, The law requires ficate has been sig				 -		<u></u>			rmed?	prior to completion of cause death? 1 Yes 2 No
tal Rec		25. Was case referred to medic	cal			26.Pla	ace of Death (Chec	1 Yes	2 NO	1 Yes 2 No
Vital I hysician: this certifi al director,	۱۵	examiner? 1 ✓ Yes 2 No	[Hospital:	atient 2 🗸	ER/Outpa		Othor		Residence 6	Other:
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Division of Vital Records, spital or Attending Physician: The law require nearl Director: After this certificate has been similed in by the funeral director, page 2 should be certification: To Be Completed	<u> </u>	3 Suicide 6 Y Co	ould not be 28e. Place of	f Injury - At ho	me, farm,	street, factory, offic	e building, etc.	or Town, S	State)	ber or Rural Route Number, (
ig b bu		29a. Certifier 1 Certifying	Physician: To the best of	reside f my knowledg	e. death c	occurred at the time	date and place, a	nd due to the caus	se(s) and manne	Lutherville MD er as stated.
To the Howithin 24 For the Funcompletely	<u> </u>	one) 2 Medical Ex	xaminer:On the basis of e	examination a	nd/or inves	stigation, in my opin	ion, death occurred	d at the time, date	and place, and	due to the cause(s)
F S F S	E	29b. Signature and title of certi	1001	un			ense number C.M.E.		29d. Date sig July 6, 20	ned (Month, Day, Year) 07
	-	30. Name and address of personal		of death (Item	23a)					
8		Tasha Greenberg M	D. Assistant Med	lical Exam	iner 1	11 Penn Stree	et, Baltimore, N	/ID 21201		
Stat Registra		31. Date filed (Month, Day, Yea	7) 32. 32. 32. 32. 32. 32. 32. 32. 32. 32.	rar's Signatu	k .	hacke		<u></u>		
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 5:07 PM Elaine 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mercy Medical Center Balhmore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 💥 □ F Yrs Director MD 09 20 212-26-9886 Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No 28a-f sh notified Director Baltimore NA MD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code a or U.S.A. 21216 'natural', or items 23a dical Examiner must t 2401 West Lanvale Street 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black by 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry h and Mental Hygiene.
7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hospital LPN 12th grade 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Berry Jay Cee Holloway ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trausone. 3517 Edmondson Ave, Baltimore, Md 21229 Maurice Hardy-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 7/23/07 Baltimore, Md Loudon Park 22. Name and Address of Facility re of Funeral Service Licenses March F/H West 21215 Ave, Baltimore, Md 300 Wabash 3a. Part , Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I nmedia e Cause (Final disease or condition resulting in death) Methicillin Resistant Staph Aureus Bacteremia **Physician** days /Medical Due to (or as a consequence of): Examiner days myconc aneurysir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by Hypertension, Diabetes Mellitus, Peripheral vascular 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No disease page 2 s 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 2 ☐ Accident 5 ☐ Pending 1 □ Yes 2 investigation 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed

Certification: To after death.

I Director: A
d in by the fu within 24 hours a

To the Funeral I

completely filled 29a. Certifie Medical (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANTATSEN M.D. 301 STPAM Place Baltimore, MD 21202

31. Date filed (Month, Day, Year) State Registrar 0

32 Registrar's Signature 2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 4a, perMD, g869, 7/20/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 16, Day 2007 8:21 PM **Physician** Donald Wolter Hammersley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Pumphrey Funeral Home Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. 057 18/1925 1 M 2 □ F 82 WI 512-40-6467 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Bethesda MD Montgomery 10e Street and Number 10f Zin Code 10g. Citizen of What Country? USA 20814-5925 Rossmore Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates:) 942-54 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry **Medicine** 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Psychiatrist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Hammersley Mable Pierstorff ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5925 Rossmore Drive Bethesda, MD 20814-19a. Informant's Name/Relationship (Type. Print) Edith M Hammersley/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ման1 19 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc.2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation Services M00382 Stephen Lahrn un 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic Small Bowel Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

Examiner burial-trar signed by the attending physician be detached for use as the burial . J. I. 6 Bo∝ P.O. Records, Division or Vital funeral director,

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

should be filed within and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event

Physician

/Medical

Baltimore, Maryland 21215-0036

hours after death.

uneral Director: A

sly filled in by the fu ō within 24 hours at To the Funeral C Hospital

OL

YAMME

30. Name and address of person who complete

3 ☐ Suicide

29a. Certifier

29b. Signature

Medical

State

Registrar

4 Homicide

(Check only one)

0 2007

29c. License number

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Discription Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 07-17-2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ause of death (Item 23a) (Type, Print)

Natasha P. Haag MD 8600 01d Georgetown Rd. Bethesda MD 20814

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per verb 869 7-20-07 vt
State of Maryland Popariment of Health and Mental Hygiene
amend items 20a-c, 22 per lift tale 869 earl 20-07 vt

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** AM 0 5:00 Hulda /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Nursina Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 4, 19 Birthplace (State or Foreign Country) Age (In yrs, last birthday) 5. Social Security Number Funeral Months 1 □ M 2 F 96 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County works r 28a-f show notified at 1 XYes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or Items 23a or the Medical Examiner must be 21215 USA 3939 Penhurst Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. unk 11. Marital Status 1 ☐ Never Married 2 ☐ Married black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: If item 27 Is marked other the any injury or other traumatic event. the beautician cosmotology unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 N. Calvert Street Baltimore, MD 21202 Rita Jones/Comm on Aging 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Zion 7-20-07 Balto. Md. 4 ☐ Donation 5 M Other (Specify) in state 22 Novelie de l'ineral Home 65638 Na Gilmore Street 21. Signature of Funeral Service Licensee Anthony D. Pleasant Baltimore, MĎ 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) accinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine burial-transit menis Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown signed by the a Division or Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4, Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a Was an 2. No certificate 1 Yes 26. Place of Death Check onl one director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P To the Hospital or Attending Phys within 24 hours after death. ∤To the Funeral Director; Atter this 28b. Time of 28d. Describe how injury occurred funeral 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD Macen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)-MAREM TUK 501 32 Registrar's Signature 31. Date filed (Month, Day, Year)

ORIGINAL

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month JUHNSON CECIL Q:00 A M ゴリムツ 17 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M **3/**□ F Days Director 240-04-3164 19 19 VAUsual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21223 U.S.A. 33 North Catherine Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No
If Yes, Give
Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmeth. Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Ravis Walter Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5706 Newton Street, Cheverly, Md 20784 James Griggs-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/21/07 Baltimore, Md Mt. Zion 21. Signature of Funeral Service I March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HEART CONGESTIVE 2 DAYS /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC UNICNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed 21 use as the burial-transit RENA2 Division or Vital Records, P.O. Box 68760, € STAGE Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERTENTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No LVULAR HEART DISEASE 24a. Was an autopsy certificate ! 2. No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) MD. D 23300 JULY 17 BON SELONES HOSP. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATE2 2000 W 13A2TO, ST. 13A2TO. SUDKIR 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

yborn Jonnso		State of Maryland / Department of 1- For State Certificate of Registrar		ygiene Reg. No.	20 7 .302
Physicia edical Exami	an/	1. Decedent's Name (First, Middle, Last)	50	Date of Death Month Day	3. Time of Death Year 1630 hrs
Na Exami		4a. Facility Name of not institution, give street and number) 4	b. City, Town, or Location of Death	July 10, 2007 4c. Cour	nty of Death
		University of Maryland Medical Center	Baltimore		NA
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	` ` ` · · · · · · · · · · · · · · ·	Foreign
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with the Maryland s 23a or 28a-f show a e notified at once.	Director	10e. Street and Number	10f. Zip Code		What Country?
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner, must be notified at once	a D	2 529 Kink Ave 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	s Decedent of Hispanic Origin? (Sp		ace - American Indian, Black,
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than	ဝ၁	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Surna	ame)
2121 uld be fi Mental I marked	To Be	19a. Inforplant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or	SIE FOS Rural Route Number, City or	Town, State, Zip Code)
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ages I and 2 nt of Health of it: If item 2		20a. Method of Disposition 20b. Place of Disposition Removal from State 20b. Place of Disposition crematory or oth	ition (Name of cemetery, ner place)	Date / 20c. Locati	on - City or Town, State
time t. Page tment rtant;		4 Donation 5 Other Specify: G-ARRISON	ForesTV.A Cen. Ju	1/24207 Ow.	nastills MD
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra		21. Signature of Funeral Service Licensee 22. N	lame and Address of Facility BeTTS FUNEAT(1109N.CAROLIA	Home Balon	mD. 2/2/3
Physician		23a Paril. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying, such as cardiac	or respiratory arrest, shock, or	heart Approximate Interval Between Onset and
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
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Division of Vital Records, P.O. Box 68760, To the Hospital or certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ledic	d. UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		l ac a s	
Sox 6876 Jeath certificate e attending phy for use as the b	an/N	23b. Was decedent pregnant in the past 12 months?	tal death 3 Ectopic pregn		e of delivery h Day Year
Box 687 death certificathe attending p	Physician/	Prognant at time of death	her (Specify)		,
O. En at the d		Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did tobacco use c	ontribute to the cause of death?
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Rec The la icate h	Completed			performed? 1 ✓ Yes 2 No	death? 1 ✓ Yes 2 No
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Division tal or Attending a ster death. The Director: A led in by the fu	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stree		28f. Location (Street and No or Town, State)	umber or Rural Route Number, City
Divi		4 W Homicide determined (Specify) Townhouse / Rowhouse 29a. Certifier		4414 Parkton Street, Bal	
To the Ho. within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigat			
F is E	Me	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date :	signed (Month, Day, Year)
		Mlina Grassell MD	O.C.M.E.	July 13,	2007
5		Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD	enn Street, Baltimore, MD	21201	
	tate	31. Date filed (Month, Day Year) 32. Registrar's Signature	# .	21201	
Regis		1111 2 0 7001/ 1800 15 1000	SLI		

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			For State Registrar	State of Maryland		artment of rtificate o		and M		ne 0	1	2 3 3 2 3	
	Physicia		 Decedent's Name (First, Middle, Last John LeRoy Keys, 						Month	Day 2	Year OO7	4:50 AM	
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			Franklin Squar		nter	If Under 1 Yes	dale ar If Under	24 Hre	C. Date of Rists	39		nore place (State or Foreign	_
	Funeral Director		5. Social Security Number 46. Se 216-26-7248	x 7. Age (In yrs. k	Yrs.	Months Day		Min.	8. Date of Birth (Month, Day, Y Jan. 29,	ear) 1938	Mary	itry)	
	ס		Usual Residence of Decedent						Juli 27,	2,50			_
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	the M	Funeral Director	10e. Street and Number			10f. Zip Code			100	. Citizen of	What Cour	ntry?	
	3a or	Ö	3315 Putty Hill A	Avenue		212	34			US.	A		
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36	within 72 hours after death with the Maryland ene. Itan "natural", or items 23a or 28a-f ahow ite Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1√□Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2X N					y:Whit		
Maryland 21215-0036	2 hour stural	ed b	15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occ	cupation		16	b. Kind of B	usiness/ln	dustry	-
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Ž	should nd Me mark	J.	19a. Informant's Name/Relationship (T)				et and Numb	er or Rura	l Route Number, (
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Baltimore,	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The mortent: If team 27 is marked other than "natural", or teams 23a or 28a-f ahow any injury or other traumatic avent, the Marical Examinar must be multiped at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	nemoval nom State	_	osition (Name of matory or other p				c. Location			
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8760, (Value of the property of the burial-transit		dicai Examiner	shock-or-heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence). Due to (or as a consequence).	earing of):	rtery	Dis	sea s	e			Interval Between Onset and Death	
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	s that t med by e deta	by Ph	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the u	underlying cause	given in Part	l.	23e. Did toba	cco use con	tribute to t	he cause of death?	
ğ	w require been sig should b	ted t							1 🗆 Yes	2 🗆 No	3 Pro	bably 4 DUnknown	
Reco	Physicien: The law requires that the this certificate has been signed by the tail director, page 2 should be detached.	Completed							24a. Was an autopsy performe		Were autoprior to codeath?	opsy findings available ompletion of cause of	
/ita	cian: ertific	Be	25. Was case referred to medical examiner?	MA-1.				e of Death	(Check only one,				
Division of Vital Records,	Attanding Physin death. actor: After this coby the funeral directions.	၉	1 ☐ Yes ➢ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)						esidence 6 Other (Specify) se how injury occurred			
Divis	글목부리	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)			ie, farm, street, factory, office 28f. Location (St City or Town				Street and Number or Rural Route Number, m, State)			
	Hospital 24 hours a Funeral I Bely filled	edicai (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the	e time, date a ny opinion, de	nd place, ath occurr	and due to the cau ed at the time, dat	se(s) and me and place	anner as : , and due !	stated. to the cause(s)	
	To the within 2 To the complex	Me	29b. Signature and title of certifies	Mark no	\triangleright	Dag	ense number	59	600	d. Date sign	18	2007	
	1541		30. Name and addr ss of person who o	completed cause of death (Item	1 23a) (Type	, Print)	X	2 11	timore V	د ال	122	7	
	- CA	10	31. Date filed (Menths Day Year) 200	2000 Fra 32, Registrar's Signa	an Klin	Square	yr ve	19917	limore 1		100	1	_
	Sta Regista		JUL 2 0 200	selle see do	A SE	A CONTRACTOR OF THE PARTY OF TH							

	- For State Certificate of Death	Reg	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month I July 14, 200	Day Year 2359 hrs
Wedical Examine	Kim Louise Konschak 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Local		4c. County of Death
	7816 Wendover Avenue Parkville		Baltimore County
Funeral Director		Under 24Hrs. 8. Date of Birth Hours Min. June 28	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)Ohio
Maryland 28a-f show any 1 at once	Usual Residence of Decedent 10a. State	kville	10d. Inside City Limits 1 Yes 2 X No
a-f she	10e, Street and Number 10f, Zip Code	100	. Citizen of What Country?
th the Maryland 23a or 28a-f sh notified at once	7816 Wendover Road 21234		JSA 14. Race - American Indian, Black,
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens and the filed within Hydroland: "or items 23a or 28a-f should progrant: If item 27 is marked other than "natural", or items 23a or 28a-f should injury or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mex	xican, Puerto Rican, etc.)	white, etc.
ural",	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No spectrum 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Specify. 16b. Kind of Business/Industry
n "nat al Exa	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO	NOT use retired)	
5-0036 ed within 72 hour bygene. the Medical Exan	3 Meat Cutter		Grocery Store
215-0 be filed w mtal Hygin rked othe ent, the T Be Co	Tr. I dated o I dame (i not) industry	other's Name (First, Middle, Ma minica Elizabet	·
MD 21 2 should th and Me 27 is ma umatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and 8101 Timberbrooks) Karen Herold- Sister 8101 Timberbrooks		-
re, l	20a. Method of Disposition 20b. Place of Disposition (Name of cemeter crematory or other place)	ry, Date	20c. Location - City or Town, State
imo Page:	Gardens of Faith		Baltimore, Maryland
Salt Sermit Departi mport	- \ \	acility Miller-Dip Road Baltimore	pel Funeral Home
Physician	23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such		st, shock, or heart Approximate Interval
/Medical	fätture. List only bandrafuse on each line. Immediate Cause (Final disease a. Smoke inhalation		Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	81	
e l	Sequentially list conditions, if any, leading to immediate bulleto (or as a consequence of):		
Examin	cause. Enter Underlying Cause (Unsease or injury that imitated events resulting in death). Last Due to (or as a consequence of):		
te be executed sysician and transit	d		
o, e be es ysician burial	X unpended X AMENDED , 27,28a-f, perME, g870, 8/20/07	TT	23d. Date of delivery
20 2 ± 2 1 3	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	ctopic pregnancy	Month Day Year
he de hed f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I. 23e. Did tob	pacco use contribute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that is after death. al Director. After this certificate has been signed by led in by the funeral director, page 2 should be denorarification: To Be Completed by F		1 Yes	-
Records, The law require ficate has been signage 2 should be		24a. Was a autops perfori	prior to completion of cause of death?
tal Rec	25. Was case referred to medical 26.Place of D	1 Yes 2 Death (Check only one)	No 1 Yes 2 No
Vital I hysician: this certifi I director,	examiner? 1 ✓ Yes 2 No		Residence 6 Other: Scene
n of \\ ing Phy After th tuneral on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) (Month, Day, Year)	Work? 28d. Describe h	ow injury occurred
ion of vertication of vertication: After the funeral	Natural 5 Pending Fnd 7/14/2007 Fnd 11:46 pm 1 Yes		f house fire
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director: After this certificonpletely filled in by the funeral director, ledical Certification: To Be (3 Suicide 6 Could not be determined (Specify) found in house		treet and Number or Rural Route Number, City ate) over Ave. Parkville, MD
To the Hospital within 24 hours Completely filler	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date a wind one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date a wind one)	and place, and due to the cause ath occurred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
To To	and manner stated. 29b. Signature and title of certifier 29c. License nu		29d. Date signed (Month, Day, Year)
	Donna IW incut. INID. O.C.M.E	· .	July 15, 2007
Ø	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Ba	altimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) 32 Registrar's Signature		
DHMH 17 Rev 1/2001	ORIGINAL		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 38 M Kearney Bertha /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore Union Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🙀 F 215-24-7792 Director 89 4-9-1918 S.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3043 Matthews Street 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify Specify: Black 3 ☐ Widowed 4 ☑ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Schools Cafeteria 12th grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be King Tora Felder Dinkins ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3043 Matthews Street, Baltimore, Md. 21218 19a. Informant's Name/Relationship (Type. Print) Emma Kearney Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Anne Arundel Co., Md. 7-20-07 Mt. Calvary Cem. 21. Signature of Funeral Service Licensee Snafe Mela March F.H. East 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IRN the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Day 5 Other (specify) 9 ☐ Unknown certificate has been signed by i rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 □ Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

821 1 MtileAt 31. Date filed (Month, Day, Year) 2007 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

N. ENTAW of onto 308 BALTIMORE MD 2/201

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	_	State Registrar	State of Maryla		rtificate of			g. No.	7 23326		
Physicia /Medica	n al		od Lusby				July 14,		3. Time of Death 6:20 An		
Examine		4a. Facility Name (If not institution, give Corsica Hills Nu			4b. City, Town, or Centervi	Location of Death		4c. County of Death Queen Anne			
Funeral		5. Social Security Number 6. Se	x 7. Age (In yi	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1 9	Birthplace (State or Foreig		
Director			^{2M 2□ F} 87	Yrs.	Months Days	Hours Min.	May 11,	1920	laryland		
M T	-	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation			10d. Inside City Limi			
he i sh	cto	Maryland Harford		Jop	pa				1 ☐ Yes 2 N		
3 23a or 28e-f show	Dire	10e. Street and Number 2903 Old Joppa F	Road		10f. Zip Code 21085	5		g. Citizen of Wha			
TIS 234	Funerai Director	11. Marital Status	12. Was Decedent Ever in		Was Decedent of H	ispanic Origin? (Sp.	ecify Yes or No-	nited St	tates American Indian,		
- 1	2	1 ☐ Never Married ※ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give Year or Dates:		f Yes, specify Cuba 1 □ Yes 2√21No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	White, etc. White		
"naturel", dical Ex.	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Deced	dent's Usual Occup	ation during most of work	ina 10	6b. Kind of Busin			
han Mer	ğ.	Elementary/Secondary (0-12)	College (1-4or 5+)	1		during most of work () Jowlson		Fodorol	Government		
atal Hygiene, do other than "natu	Be Co	12 17. Father's Name (First, Middle, Last)		Silee	t Metal V		e (First, Middle, Ma		Government		
and Mental Is marked of	108	Walton Lusby				Ora H	Hicks				
Department of Health and Menta Important: If item 27 is marked any injury or other treumatic a once.		19a. Informant's Name/Relationship (7) Patricia Barth (Ni			-	and Number or Russ a Road, Jo			te, Zip Code)		
of Hear		20a. Method of Disposition 1%∑8urial 2 ☐ Cremation 3 ☐F		. Place of Dispo cemetery, cren	sition (Name of natory or other place	(9)	Date 20	Oc. Location - Cit	y or Town, State		
ment tant: I		4 Donation 5 □ Other (Specify)	Re	surrect		etery July					
Depart Import any in		21. Signature of Funeral Service Liggis	I mooas	100		ss of FacilityLee Ferry Roa			20735		
hysician		23a. Fart1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the dene cause on each line.	De hold	thy		or respiratory arres	st,	Approximate Interval Between Onset and Death		
/Medical xaminer		resulting in death)	Due to (or as a cons	Lie sta	lvular a	licesse			years		
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physician and the burial-transit	edicai Exami	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):							
		IF FEMALE:									
r death. setor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	fdelivery Day Year		
been signed by should be detac	ed by Pr	Part II. Other significant conditions co. Dem entu	ntributing to death but not r	esulting in the ur	nderlying cause give	en in Part I.			te to the cause of death?		
ate has been page 2 should	Completed						24a. Was an autopsy performe	prior deat	e autopsy findings availat to completion of cause o h? Yes 2 \(\subseteq \text{No} \)		
certificate rector, pag	e c	25. Was case referred to medical examiner?	fospital:		Othe		(Check only one)				
After this certificate hir funeral director, page	0	1 ☐ Yes 2 ☑ No	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of		ar: Nursing Ho	me 5 Residen 28d. Describe how		Specify)		
death. ctor: After y the funer	ation	1- Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		(? Yes 2□No					
within 24 hours after death. To the Funeral Director: Aftert completely filled in by the funeral and a funeral an	ertitic	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number o State)	r Rural Route Number,		
Funeral stely fille	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my op	e, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manne e and place, and	r as stated. due to the cause(s)		
	لة له	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (N	fonth, Day, Year)		
To the comple	Σ		0-3			-310		- M			
To the comple	Σ	> Illistro	TIME		D	25933		F. M.	7		
within 2 To the comple		30. Name and address of person who co	Impleted cause of death (It	em 23a) (Type, 1	Print) Lame E	15933 (140n 2	21601	4.14.6	07		

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Ü	Physici	an	1. Decedent's Name (First, Middle	le, Last)					2. Date of De Month	eath Day	Year	3. Time of De	eath M
	/Medic		4a. Facility Name (If not institutio		mber)		ogan 4b. City. Town. o	r Location of Dea		7- 12 2007 1:p M			IVI
A	Examir	ier	54 N. Twin C		,			thorpe			Baltir		
	Funeral Director		5. Social Security Number 219–40–4679	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday) 54 Yrs.		If Under 24 Hrs Hours Min		ay, Year)	9. Birth	place (State or F	oreign
	PL ,		Usual Residence of Decedent		140. 0					1342			
	show show	5	Md. 10b. County	NA	100.01	ty, Town or Lo						10d. Inside City I 1 XYes 2	
	the N 28a-f notifie	Director	10e. Street and Number	IVA		pal	timore 10f. Zip Code			10a Citi	zen of What Cou		
	3a or		54 N. Twin C	ircle Wav			212	27		rog. Om	USA		
	death	Funeral	11. Marital Status		edent Ever in U	J.S. 13. V	Vas Decedent of H	lispanic Origin? (Specify Yes or No	0-	14. Race - Ameri		
215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinar must be notifled at	þ	1 □ Never Married 2√2 Mar 3 □ Widowed 4 □ Divorced	ried 1 ☐ Yes	2 No		Yes 2XX No	Specify:	no Aican, etc.)		Black, White, Specify: Bla		
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Maryland	eve eve	To Be	Kennie	R.	I	Logan		Elizab		, waiden	Stone		
lar	and sund sund sund sund sund sund sund su		19a. Informant's Name/Relations				g Address (Street					p Code)	
_	s 1 and 2 if Health item 27 i		Diana Logan 20a. Method of Disposition	Wi	fe		. Twin C	ircel Wa	y, Balti Date		, Md. 2	21227	
Jor	8 5 = 0		1√2 Burial 2 ☐ Cremation		State	cemetery, cren	natory or other pla	i i			<i></i>	, -	
Baltimore	구두막근		4 Donation 5 Other (5			rinity 22	. Name and Addre	see of Facility	1-07		ndalk, M	ia.	1357
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		s 77	23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that of t only one cause on e	aused the dea ach line.	th. Do not ente	erthe mode of dyi	ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Betwe Onset and Dea	en ath
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		Ψ.	IF FEMALE:	23c. If yes, out	tcome pf pregn	ancv					22d Data of dolin		
Box	death certifi e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live t	oirth 2 ☐ Fet nant at time of	al death 3□	Ectopic pregnanc Other <i>(specify)</i>	у		1	23d. Date of delive Month	Day Yea	ar
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ord	w require been si should b			-					1 🗆	Yes 2	□ No 3 □ Pro	bably 4 U nl	cnown
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or Vital	<u>5</u> 9 9	Be	25. Was case referred to medica examiner?	Hospital:			• act pox Oth	0.00	eath (Check only				
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	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	29a. Certifier 1 Y Certifyi (Check only one) 2 Medica	ng Physician: To the I Examiner: On the b and man	asis of examin	ation and/or in	vestigation, in my	opinion, death oc	curred at the time	e, date and	d place, and due	to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certific	er Ma	0		29c. Licens	se number		29d. Da	te signed (Month	, Day, Year)	
	1		Wills a	1/			200	85780	2	JULI	1 13, 20	007	
	H		30. Name and address of person WELLS MES	who completed caus	se of death (Ite	m 23a) (Type,	29c. Licens D Ø (adule.	Ba Horan .	ce 1	Yeels	121231)
	Sta	ate	31. Date filed (Month, Day, Year	2007	Registrar's Sign	ature Cha	all)	7	11110	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	נשטנאא	J 1	
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heem Muham		State of Maryland / Departmen 1- For State Certificate		i Mentai Hyg		0.0	17 9999
		Registrar 1. Decedent's Name (First, Middle,Last)	Orbeatt	2	Reg. No. 1		3. Time of Death
Physicia edical Examir			Muhamma	ا ہ	Month Da July 14, 2007	y Year	0321 hrs
		Raheem Rasheedah 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or L	ocation of Death		4c. County of Deat	h
		1903 N. Forrest Park Ave.	Baltimore			2 2 2 2 1 C D	theless (Cloto or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year Months Days		8. Date of Birth (N	M/DD/YYYY) 9. Bi Forei	gn
Director		216-92-9613 1 M 2XF 29	Yrs.		09 06	77 C	ountry) MD
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ow any							1 Yes 2 No
yland a-f sh	흱	MD NA Baltime	10f. Zip Code		10g.	Citizen of What Co	untry?
or 28	ire		212	07		U.S.A	_
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral Director	11. Iviantai Status	3. Was Decedent of His	panic Origin? (Spe			rican Indian, Black,
leath r item	nue	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban,	, Mexican, Puerto H	ican, etc.)	D	lack
F . 1	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No		lace lace	ороону.	
hours after 'natural'', Examiner		dur	cedent's Usual Occupati ing most of working life.			b. Kind of Business	rindustry
an "72	plet	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 4yrs Adm	inistrati	ve Assi	stant	Kennedv	Staffing
5-0036 ed within 72 tygiene. other than '	Completed	17. Father's Name (First, Middle, Last)		18.Mother's Name (
21215-0036 utilitie filed within 7 Mental Hygiene. marked other than cevent, the Medica	BeC	Rasul Muhammad		Regina			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mqutal Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical.	TO	1	Mailing Address (Stree				
MD d 2 sho Ith and u 27 is	·	1.02	20 Rucker			e, Md 2 0c. Location - City	
re, 1 and 1 Heal 1 item er tra			Disposition (Name of cer or other place)	metery,	Date	oc. Location - City	or rown, clute
altimore, mit Pages I ar spartment of Hee sportant: If ite	ı i	Garris	on Forest	Vet 7/2	3/07	Owings	Mills, Md
Salti Sermit Departm Import,		21. Si nature of Funeral Service Licensee	22. Name and Address March F/H	of Facility West			
		23a. Part I. Enter the disease or complications that caused the death. Do not of	MR300 Waha	Sh AVe	Baltin respiratory arrest	shock, or heart	21215 Approximate Interval
Physician Medical		failure. List only one cause on each line.	antor the mode of dying,				Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):					
		h					
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
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ecuted and transit		d.					
e exec sian ar ial - tı	lical		. 7/20/07 TT				
Box 68760, e death certificate be exthe attending physician ed for use as the burial	an/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy			11	23d. Date of deliv	ery Day Year
687 certific ding	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 pregnant at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	ncy	Month	Day Tear
Sox Jeath e atter	Physici	1 Yes 2 No 9 V Unknown g Unknown	Other (Specify)				
O. E at the a			n the underlying cause	given in Part I.			to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	d by				0.000	- RESPONDED	robably 4 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	Completed	<u></u>			24a. Was an autops)	prior	autopsy findings available to completion of cause of
ecol he law nte has	ПE				perform 1 Yes 2		Yes 2 No
Vital Rec ysician: The his certificate director, page	Be C		26.Plac	e of Death (Check			
Vita sysicia this ce	0	1 Yes 2 No 1 Inpatient 2 ENOU	patient 3 DOA		9110	esidence 6 🗸 O	her: Scene
n of Vi ling Physi After this funeral dir	٦ ا		. ''	ury at Work?	28d. Describe ho Victim of hou	w injury occurred sefire	
ion tendi leath tor: ,	atio	1 Natural 5 Pending Jul 14, 2007 0310 2 🗸 Accident Investigation		Yes 2 ✔ No	001 15- 101	I d N. umbos os	Rural Route Number, City
Division pital or Attendion ours after death neral Director: Afilled in by the fi	Certification:	3 Suicide 6 Could not be		building, etc.	or Town, Sta	te) Park Ave., Balti	more. Md.
Spital nours neral	Se	4 Homicide determined (Specify) Multi-Family Apt.			- HOPCE	E	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	cal	29a. Certifier Certifying Physician: To the best of my knowledge, deat (Check only one) 2 Medical Examiner: On the basis of examination and/or in	h occurred at the time, overtigation, in my opinion	date and place, and on, death occurred a	it the time, date a	nd place, and due to	the cause(s)
To the Comp	Medical	and manner stated. 29b. Signature and title of pertifier		ise number		29d. Date signed (
	=	1 / linko . 1. D	0.C	.M.E.		July 14, 2007	
		30. Name and address of person who completed cause of death (Item 23a)					
5+	1	Laron Locke MD. Assistant Medical Examiner 111	Penn Street, Balti	imore, MD 212	01		
	tate	a 31. Date filed (Month, Day, Year) 32. Registrar's Signature					
Regis		JUL 2 0 2007 A	1.00				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

07-05506

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

iomas McDanie		State of Maryland / Department of Health and For State Certificate of Death	Reg. I	
Dhyminia	R	egistrar December's Name (First, Middle,Last) Thomas McDaniels, Jr.	2. Date of Death	3. Time of Death
Physicial edical Examin	-	Thomas M. Daniels, Til	July 18, 200	ay ^{Year} 0735 h r s
		ta. Facility Name (if not institution, give street and number) 4b. City, Town, or	Location of Death	4c. County of Death
		6918 Upper Mills Circle Catonsville		Baltimore County MM/DD/YYYY) 9. Birthplace (State or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Day	s Hours Min.	Foreign Country)
Director	(212-58-0945 1XM 2 F 58 Yrs.	107/01/1	949 Country) 11D
	61 477	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
and show any nce.	l	MD Baltimore Catonsville		1 Yes 2 No
ryland a-f sh	핡	10e. Street and Number	. 10g.	Citizen of What Country?
death with the Maryland or items 23a or 28a-f sh must be notified at once	ē.	19.0/1 Mil Minds	228	USA
with the s 23a e noti	la l	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi	spanic Origin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
leath v	nue	1 Never Married 2 Married Armed Forces? If Yes, specify Cuba	n, Mexican, Puerto Rican, etc.)	Dical
er,	by	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 No	specify:	Specify: DIUCK 6b. Kind of Business/Industry
hours at		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa during most of working life	a. DO NOT use retired)	BB. Kill of Busiless/illustry
136 hin 72 l e. than ";	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) Environment	1 Tech	Health (are.
5-0036 lled within 7 Hygiene. I other than the Medica	E	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Me	iden Surname) /
21215-00 und be filed wit Mental Hygien marked other c event, the M.	Be C	Thomas McDiniels, Je.	Rebecca T	owell
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "nature or other traumatic event, the Medical Exam	2	19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	eet and Number or Rural Route Number	
MD id 2 sho lith and m 27 is sumati		Kase K. Darden - McDaniels (Wite) 6918 Upper/)	M:11 Circle, Cator	20c. Location - City or Town, State
ore, MD ss I and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition 20b. Place of Disposition (Name of Company) Burial 2 Cremation 3 Removal from State crematory or other place)		0 . 1
Page Page or oth	ļ	4 Transition 5 Other Specify: Proutos Cemer	ery +12410+	Baltimore, MD
Baltimore, permit. Pages 1 a Department of He Important: If it injury or other t		1) / 1		Balto, MD 21229
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying	g, such as cardiac or respiratory arres	st, shock, or heart Approximate Interval
Physician /Medical		failure. Defonly one cause on each line.		Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Chest and abdominal injuries complete to (or as a consequence of):	1Cared by ernanol 1m	COXICATION
		Sequentially list conditions, b.		
	iner	If any, leading to immediate Due to (or as a consequence of :		
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760, Trate be g physici the buri	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	Ectopic pregnancy	23d. Date of delivery Month Day Year
Sox 6876 leath certificate e attending phy for use as the l	ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		
Box 687 e death certificathe attending p	hysi	1 Yes 2 No 9 Unknown 9 Unknown	230 Did tol	pacco use contribute to the cause of death?
i, P.O. Barries that the designed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	1 Ves	2 ✓ No 3 Probably 4 Unknown
S, P uires t n sign Id be c	a pa	Hypertensive atherosclerotic cardiovascular disease	e, history 24a. Was a	n 24b. Were autopsy findings available
ord w req as bee s shou	plet	of lung cancer	autops perform	med? death?
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the later death. "In Director: After this certificate has been signed by the funeral director, page 2 should be detach	Be (25. Was case feleried to filedical	Other Nursing Home 5 I	Residence 6 Other: Scene
f Vi Physic er this	70	1 Ves 2 No		now injury occurred
ding h. Afte	on:	(Month, Day, Year)	Yes 2 X No subject	fell while intoxicated
Sio	cati	2 X Accident Investigation PIII 7 10/2007 PII 7 10 all 28e. Place of Injury - At home, farm, street, factory, office	e building etc. 28f Location (S	Street and Number or Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) residence	6918 Uppe	er Mills Cir. Catonsville, M
Hospin 4 houn Funer ely fil		29a Certifier Take heat of multiple docth occurred at the time	, date and place, and due to the caus	e(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin	ion, death occurred at the time, date	and place, and due to the cause(s)
F \$ F 8	Me	29b. Signature and title bit certifici	ense number	29d. Date signed (Month, Day, Year)
			C.M.E.	July 19, 2007
OCME		30. Name and address of person who completed cause of death (Item 23a)	eet, Baltimore, MD 21201	
		1992 Devictorie Signature	et, Daitimore, MD 2 1201	
S Regis	tate stra			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc 2869 7-20-07 with and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** S: OSPM Joann McCall 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**V**□ F 214-58-7099 56 9-24-1950 Director Md. Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1. TYes 2 No MC Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 E. 33rd Street 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status "natural", or item dical Examiner Black, White, etc. Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Y Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medica once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodial Abacus-Janitoral Co. llth grade N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Codell McCall Ethel Timmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel Evans Sister 1211 Linworth Avenue, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery 7 7/19/2007 Baltimore MD 21. Signature of Funeral Service Licensee March F.H. East 1101 E. North Ave., Baltimore, Md. was 21202 2 am 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Jeutropenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Nasopharyhgeal and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bivision or Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes been si should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

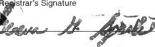
1 ☐ Yes 2 ☐ No page 2 autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔁 No ၉ 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 TYes To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P

State Registrar

, Union Maurice Sheppard 31. Date filed (Month, Day, Year)

32. Registrar's Signature



ORIGINAL

Memorial Hospital, Balt Mi 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Shirley NASH 25 PM 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3209 Fox Glove RIVER LANC Middle If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 214-32-2309 72 Director MARY/AND OV 22, 1934 Usual Residence of Decedent 10a. State 10c. City, Town or Location Show 10d. Inside City Limits r 28a-f show notified at Middle 1 ☐ Yes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? ortant: If item 27 Is marked other than "natural", or Items 23a or Injury or other traumatic event, <u>the Medical Examiner must be</u> 3209 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dept of Public WORKS Secretary 12 th and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any Injury or exercise. Charles CAPP Helen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi. Code) 2/220 NASIL 3209 Fox Glove Line MUSBAND Middle Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BAHIMORE MARYLAND 4 □ Donation 5 □ Other (Specify) Morelmas Menorias Paric July 21, 2007 22. Name and Address of Facility JOSEPH N- ZANNINO J 263 3. Conkling St. E 21. Signature of Funeral Service Licensee 21224 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** IRTNARY RACT DAYS /Medical Due to (or as a consequence of): Examiner EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit RO and Due to (or as a consequence of): physician a Box 68760. Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Nio
9 Unknown 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 2 \No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1-Natural 5 Pending investigation Injury 1 □ Yes 2 □ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

4 Maser

3100

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

2007

31. Date filed (Month, Day, Year)

Do059076

2007

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please	Type or Print in				-	•	
For State	State of Maryla	•	artment of F <i>rtificate of</i>				3000
Registrar 1. Decedent's Name (First, Middle, Las	<i>it</i>)		, , , , oato or		2. Date of Deat		3. Time of Death
LOUISE LAURA PET	,				Month JULY	Day Year 17 2007	
4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	-	4c. County of Dea	
OAKCREST NURSING				RE COUNTY		BALTIMO	
5. Social Security Number 6. Social Security Number 1	ex 7. Age (<i>In y</i>	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 9.	Year) C	thplace (State or Foreign ountry)
Usual Residence of Decedent					100.0,	1024 110	
Maryland Baltimon		City, Town or L	ocation Ltimore Co	ountv			10d. Inside City Limits 1 ☐ Yes 2 XXIo
10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
8832 Walther Blvd	dCottonwoo		212			USA	
11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp ean, Mexican, Puerte	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 / ☐ (No	Specify:		Specify: V	lhite
15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	edent's Usual Occup kind of work done	pation during most of work d)	king	16b. Kind of Business	:/Industry
Elementary/Secondary (0-12)	College (1-4or 5+) N/A		sewife	· · · ·		Housekeeni	.ng~Own Home
17. Father's Name (First, Middle, Last)	•	1100		18. Mother's Nam	ne (First, Middle, I		
Herbert Brent				Laura	Louise	Walters	
19a, Informant's Name/Relationship (7	Type. Print)	19b. Mail	ing Address (Street			City or Town, State,	Zip Code)
Mary Schaefer (Da				t. East B	elair Md	. 21014	
20a. Method of Disposition *XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content	Removal from State	cemetery, cre	osition (Name of ematory or other pla of Faith	i i		20c. Location - City o Baltimore,	
21. Signature of Funeral Service Vicer			2. Name and Addre	ess of Facility Funeral H	ome		
23a. Parts thater the disease, or com	prestions that caused the de	eath. Do not en				<u>, Md. 2123</u>	Approximate
Ushock, or heart failure. List only immediate Cause (Final disease or condition	one cause on each line.				or roopmatory an	551,	Interval Between Onset and Death
resulting in death)	Due to (or as a cons	equence of):					
Sequentially list conditions,	b. Decubit						Lycar
if any, leading to immediate cause Enter Underlying Cause (Disease or injury	Due to (or as a cons						10 years
that initiated events resulting in death) Last	c. Multiple Due to (or as a cons	equence of):	7031				1.1
	- d	,					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	□Ectopic pregnand □ Other (specify) _	гу		23d. Date of d Month	elivery Day Year
Part II. Other significant conditions of	contributing to death but not	resulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
					1 □ Y	es 2⊠No 3∐F	Probably 4 Unknown
					24a. Was a		autopsy findings available
					autops perfor 1∐ Yes	sy prior to med? death?	completion of cause of
25. Was case referred to medical examiner?	Hospital:				ath (Check only or	ne)	
1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatie	III 3 DOA			ence 6 Other (Sp	ecify)
1 Naturai 5 ☐ Pending	(Month, Day Year		Wo	ıryat ork?]Yes 2 ∐No	Zou. Describe h	ow injury occurred	
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		t home, farm, s ecify)			28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,
	nysician: To the best of my niner: On the basis of exam and manner stated.						
29b. Signature and title of certifier	a Aurel	ers	29c. Licen	3017	2	29d. Date signed (Mod ろいし」(フ	nth, Day, Year)
30. Name and address of person who	completed cause of death (I	tem 23a) (Type	e, Print)	idit	Len3 IV	1. Baltin	, 2007 we MBZ1234

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

State

Caton

31. Date filed (Month, Day, Year)

Baltimore

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician QUAIIS 3:38 PM HUZEI JUly 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore U. of Maryland Medecal Center Baltsmore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Director 24 NC 22 238-46-5450 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 1 ☐ Yes 2 XNo Director Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 U.S.A. Completed by Funeral 7070 Cradlerock Way Apt 205 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Beautician 2yrs Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Eliza Mason Horace Whitaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirb Qualls Sr.-Husband 7070 Cradlerock Way Apt 205, Columbia, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 21045 20a. Method of Disposition Date 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Qualls Family 7/ 22. Name and Address of Facility March F/H West 7/23/07 Enfield, NC 21. Signature of Funeral Service Ligenses 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Resperatory tailure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Multiple ischemic strokes Sequentially list conditions, one to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760² been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manater of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P21178 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar José C. Cabassa

20

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

305 W. Fayette Sto Aph# 1508

Baltimore, MD 21201

07-05382 Royelle Riley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day July 14, 2007 Year 0321 hrs Medical Examiner Riley Edward Royelle 4c. County of Death 4a. Facility Name (if not institution, give street and number)
1903 N. Forrest Park Ave. 4b. City, Town, or Location of Death Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Linder 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Davs Hours Min Country) Director 15 97 MD 07 2 9 Vrs 220-49-3343 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 2 YYes 2 No s 23a or 28a-f show e notified at once. 28a-f show Baltimore NA Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21207 Forest Park Ave 1903 North Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status narked other than "natural", or items event, the Medical Examiner must be White, etc. Armed Forces? 1 X Never Married 2 permit. Pages 1 and 2 should be filed within 72 hours after death pagarment of Health and Mental Hygiene.

Important: If item 27 is marked at the page of the page 1. Yes 2 X No Black Yes, Give Year Yes 2 X No specify: Specify. Widowed Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) School Student 5th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy Riley Raheem Muhammad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, 2120 Tucker Lane, Rilev-Father Roy Riley-20a. Method of Disposition 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Garrison Forest Vet 7/23/07 Owings Mills, Md Donation 5 Other Specify: 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 21215 4300 Wabash Baltimore, Ave, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Smoke Inhalation Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical UNPENDED ##ENDEDSf, perME, g869, 7/20/07 TT nttending physician or use as the burial certificate be Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) The law requires that the death 1 Yes 2 No 9 Unknown For g Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Yes 2 No 3 ✓ Probably 4 Unknown Records, P. Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy ficate has b page 2 sho performed? death? Yes 2 V No Yes 2 No certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica Division of Vital Be Other₄ Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 DOA Innatient 2 this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Certification: Victim of housefire Jul 14. 2007 0310 hrs Natural Yes 2 V No Pending Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 1903 N. Epirest Park Ave., Baltimore, Md. Suicide determined (Specify) Multi-Family Apt. Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the 1 one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 14, 2007 O.C.M.E. incerti, M.D. Nonno mi 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Day, Year 32. Registrar's Signature State 0 2007 Registrar

DHMH 17 Rev 1/2001

OCME

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. America at a of Manyland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 14, 2007 1:57P ROUZER JULY JANE R /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Pay, Year, Aug 25, 1920 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months Days Hours Maryland 1 □ M 2 🗶 F 86 215-07-7192 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2√☐ No Director MD Howard Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ral", or items 23a or Examiner must be 21771 United States Funeral 1032 St. Michaels Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXXIo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status "natural", or items Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXXNo Maryland 21215-0036 Specify: White þ 3₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) her have Homemaker 9th permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Evans Franklin Reidv 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16549 Old Frederick Rd. Mt Airy, MD 21771 Terry Fortin (daughter) **Baltimore**, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem Gardens 7/17/2007 Marriottsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smediate Course (Fig. 1). Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) DIRATORN /Medical Due to or as a conse pence of): -30 min Examiner Terminal **Aspiration** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner astrointestina burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day ☐Yes 2 No 9 Unknown us certinicate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SOUMAGIT autopsy 2 X No 2 No 1□ Yes To the Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XInpatient 2 ER/Outpatient 3□ DOA 2**X** No 1 ☐ Yes Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Fun completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JULY 15, 2007 00650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

(5A)

2007

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

	1 = For State Registrar	State of Maryland / Department of Health and N Certificate of Death	Reg. No. 2007 23333
Physician	146 6 6 60	RIDGEWAY	2. Date of Death Tulu 17, 2007 9:05
/Medica Examiner Funeral	4a. Facility Name (If not institution, girls Second 5. Social Security Number 6.	Battimore 7. Abe (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign Country)
Director	Usual Residence of Decedent	Yrs.	July 25,1923 Maryland 10d. Inside City Limits
e Marylar la-f ehow	10a. State 10b. County	A Baltimore	1 XYes 2 No
th with th	10e. Street and Number 2015 Popla	r Terrace 2/2/6	10g. Citizen of What Country? USA
urs after death with the Mar urs after death with the Mar et', or fleme 23a or 28a-f el Everifier must be notified by Eumanel Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examinar must be notified at once.	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	16b. Kind of Business/Industry Poilto Co. Pub School
Maryland 2 d 2 should be filed th and Mental Hyg th and Mental Hyg traumatic event,	17. Father's Name (First, Middle, Las		e (First, Middle, Maiden Surname) et Rhuehottem
and 2 shou lealth and M	19a. Informant's Name/Relationship Mr. Bernard	Ridgeway 3015 Poplar Terr	Pal Route Number, City or Town, State, Zip Code) Ace Balt, Malale Date 20c, Location - City or Town, State
altimore, mit. Pages 1 a portment of Hez portant: If flem y injury or other.	20a. Method of Disposition 1 Burial 2 Communication 3 (Removal from State cemetery, crematory or other place)	Date 20c. Location - City or Town, State 23/2007 Baltz Md
Baltimo	21. Signature of Funeral Service Lice	L. Kuss 2222 W. North A	Funeral Home, P.A.
) Physician	shock, or heart fallure. List only Immediate Cause (Final disease or condition	in Dications that caused the death. Do not enter the mode of dying, such as cardiac one cause on each line.	Interval Between Onset and Death
/Medical Examiner	resulting in death) Sequentially list conditions.	Due to (or as a consequence of): b. COILONARY MIHEROS	CLCROSIS
ficate be executed in the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be exwithin 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physicien a completely filled in by the funaral director: page 2 should be detached for use as the burial modern of the funaral director.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
IS, P.	Talcii. Othor significant containers	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ☐ Onknown
Division of Vital Records, for Attending Physicien: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	1471	- TENSION	24a. Was an autopsy enformed? death?
Vital	25. Was case referred to medical examiner?	Hospital:	1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No th (Check only one)
ng Phys	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Division of Vital Rec To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2.	27. Manner of Death 1	DB Diago of Jaiway Athanas farm street factors office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospital 24 hours Funaral stely filled	29a. Certifier 12 Certifying F	hysician: To the best of my knowledge, death occurred at the time, date and place miner: On the basis of examination and/or investigation, in my opinion, death occu and manner stated.	and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
To the within To the comple	The state of the s	29c. License number 12006143	29d. Date signed (Month, Day, Year)
io	30. Name and address of person who	comp sie, cause of death (Item 23a) (Type, Print)	RIBELTY HEIGHT WE SALTIMOLE, MD 21215"
State Registra	31. Date filed (Month, Day, Year)	32. Registrar's Signature	SUFTIMOTE WID STATE
DHMH 17 Rev 1/200	11	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 3:00 A^M 17 2007 George H. Seiler, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Elder Care Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months XXM 2 F Days Hours Director 218-14-8814 84 2-3-1923 MD Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f sh notified a 1 Yes 2XNo Director MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or items 23a or? o e ns 23a (21090 USA 105 Babet Way Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced Year or Dates er than "natura , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Tools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Item 27 is marked other traumatic ev Cora Blum ပ George H. Seiler, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Catonsville, 19a. Informant's Name/Relationship (Type. Print) Mrs. LaVerne Seiler/ Wife 719 Maiden Choice Ln. Apt. HR543; 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 19 Chesapeake Cremation 2007 Stevensville, MD 21. Signature of Service Licensee 22. Name and Address of Facility 1 Second Ave. SW M01411 Singleton Funeral Home; Glen Burnie, MD 21061 Approximate Interval Between Onset and Deat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medicai Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical use as attending p IF FFMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month signed by the a 5 ☐ Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe page 2 or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27, Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 1 Maturai (Month, Day Year) Injury s after deav. 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕡 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

P.O. Box 68760, Division or Vital Records. within 24 hours a

To the Funeral I

completely filled the Hospital

> ns they Millersville MD 31. Name and address of person who completed caus 5 enni er 31. Date filed (Month, Day, Year) State JUL 2 0 200 Registrar

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month. Dav. Year)

			1- For State of Mary		artment of H			giene Reg. No.	7 23340
			Decedent's Name (First, Middle, Last)			-	2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Joseph Leonard Snier				July	17 200	7 1:40 PM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of E	Death	4c. County of D	eath
		٠	Levindale Nursing Home			imore			
	Funeral		1177 M 2 □ F	n yrs. last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, Da)	y, Year)	Birthplace (State or Foreign Country)
	Director		178-22-4790 78 Usual Residence of Decedent				June 28	, 1929 Pe	nnsylvania
	yland iow			C. City, Town or Lo	cation				10d. Inside City Limits
	Mar- in-	tor	Maryland Baltimore		Baltimo	re			1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	23a	erai	9601 Westcott Way		2123				S. A.
	er de	Fune	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin I n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	- 14. Race - A Black, V	American Indian, Vhite, etc.
36	rs aft	by F	1 Never Married 2 X Married 1 X Yes 2 No If Yes, Give Year or Dates:	1	1□Yes 2K No	Specify:		Specify:	White
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. Id other then "neturel", or items 23a or 28a-f show event. The Medical Examinational be notified at		15. Decedent's Education	16a. Deced	ient's Usual Occup	ation		16b. Kind of Busine	
215	hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	during most of ()	working		
2	filed wil Hygien other th	Con	12	Elec	tronics l	_			Company
nd	tal Hydral Hydral even	Be	17. Father's Name (First, Middle, Last)				Name (First, Middle,		
yla	2 should be and Mental is marked o	T ₀	John Snier	401 44 11			ary Shadwi		7.0.11
Maryland	ges 1 and 2 should it of Health and Men If item 27 is marke or other treumetic		19a. Informant's Name/Relationship (Type, Print)		•		r Rural Route Numbe		
	s 1 and 3 if Health item 27 other tre		Gloria Snier (Wife) 20a. Method of Disposition	20b. Place of Dispos	sition (Name of		Baltimore Date	20c. Location - City	
Baltimore,	p. rmit. Pages. Department of It Importent: If ite any injury or of			Dulaney V		9)	(10.40007		52 S S
altir	arith. Parithe		21. Signature of Funeral Service Licensee	Memorial 22	Gardens . Name and Addres	ss of Facility	/19/2007 Schimunek	Fimonium,	Maryland
ď	Depa Impo any ii		Buin a Willer	9	705 Bela:	ir Road	d, Baltimo	runeral Hore re. Marvl	and 21236
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
Ų,	Pnysician		Immediate Cause (Final disease or condition A C U	te my	ocardio	al iv	faretic	n	30 minutes
	/Medical Examiner		resulting in death) Due to (or as a co	onsequence of):		1.			
	Examine	_	Sequentially list conditions from leading to immediate b. Due to (or as a co	ary ar	tery	dise	93e		> 6 months
	led sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	insequence or):	20000	114101	cular d	150.050	7 6 months
^	xecul and al-trar	Examine	that initiated events resulting in death) Last C. Due to (or as a co	onsequence of):	ie care	110045	eular 9	Perioe	7 0 1101
8760,	death certificate be executed attending physician and of for use as the buriat-transit	dicai E	d						
9	tificat ng phy as th	ledi							
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐		Ectopic pregnancy			23d. Date of	
	ne dea the att	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown		Other (specify)			Month	Day Year
P.0	ac o	Phy	Part II. Other significant conditions contributing to death but no	ot reculting in the ur	adortvina couso div	on in Part I	23e Did to	obacco use contribut	e to the cause of death?
ds,	requires that the	d by		fibrilla					Probably 4 □Unknown
Division of Vital Records,	~ D (A	Completed	Hypertension, Demen	Da of	Aladas'ı	one di	50950 24a. Was	an 24h War	autopsy findings available
Re	e la has	mc	right rension, Demen	THE OF	MIZ METM	213 41	репо	osy prior death	to completion of cause of 1?
tai	icien: Th certificate ector, pag	a	25. Was case referred to medical			26 Place of	1 ☐ Yes Death (Check only o		Yes 2□No
<u> </u>	Physicien: r this certific ral director,	To B	examiner?	2 ER/Outpatien	t 3 DOA Othe	4.14	ng Home 5 Resid		Specify)
0	ng Ph		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injun Worl			how injury occurred	
Siol	endir eath. or: Al	atic	2 Accident investigation		M 1 []	Yes 2 □ No	1		
ΞŽ	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (S City or Tow	Street and Number of vn. State)	r Rural Route Number,
	pital ours a erei [29a. Certifying Physician: To the best of m	vy knowlodno dooth	a neguerad at the time	o data and r	lace, and due to the		t on atotad
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edicai	(Check only one) Medical Examiner: On the basis of examiner one) American Examiner on the basis of examiner one)	amination and/or inv	estigation, in my of	pinion, death	occurred at the time,	date and place, and	due to the cause(s)
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier		29c. License	number		29d. Date signed (M	onth, Day, Year)
)	1		b (Segum, MD					07/17/	2007
1	01		30. Name and address of person who completed cause of death 2434 W. BELVEDERE	(Item 23a) (Type, I				MD	
	١~		2434 W. BELVEDERE	AVE,	BALTIM	DRE,	MD - 2	21215	
	Sta Registr	-	31. Date filed (Month, Day Year) 32. Redistrar's	Signature	Possel)				
	riegisti	aı	70000	5	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 18 2007 July 06:30 aM Alvera D. Severino 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Min. Hours Months Days 1 □ M 2 🛱 F 1922 1, Jan. Connecticut 044-12-0269 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Owings Mills Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 21117 3440 Associated Way 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 21 No Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) B. F. Goodrich Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michelena Unknown Charles Livolsi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3512 Stoney Creek Ct., Owings Mills, Md. 21117 Janet Walinski (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 07/19/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nan disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 monthe? 1☐ Yes 2☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

Directo

by Funeral

Completed

Be

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be

00 of Health

Important: If it any injury or conce.

Maryland

Baltimore,

D

physician ar as

Physician/Medical ò Completed Be Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760.

IF FEMALE: 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed? Yes 2 10 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

2☐No 1 Inpatient 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 □Pending investigation 2 Accident

6 ☐ Could not be

28b. Time of 28c. Injury at Work? Injury M

1 Tes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

(Check only one) 29b. Signature and title of gertifier

3 ☐ Suicide

4 ☐ Homicide

31. Date filed (Month)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

ss of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		tificate of l		F	Reg. No.		233	1,2
	Physicia	an	1. Decedent's Name (First, Middle, Las		Ti o i o ole			2. Date of Dea	Day Y	'ear	3. Time of [
	/Medic	al	Theodore 4a. Facility Name (If not institution, give		Siejack	4b. City, Town, or	Location of Deat	July 17	, 2007 4c. County of	Death	15:16	P™
	Examin	er	6907 Markel Avenue				Dundalk Baltim					
S _{ee}	Funeral		5. Social Security Number 6. Se	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h 9	Birthp	ace (State or try)	Foreign
	Director		214-30-1909	∑ ^{M 2□F} 64	Yrs.	World Days	Tiours Willi.	Oct. 2		Md.		·
	w		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				1/	0d, Inside City	y Limits
	Maryle f sho ied at	JO.	Md. Baltir	nore	Du	ndalk					1 □Yes	2 X]No
	r 28a- notifi	irect	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Coun	try?	
	th with	Funeral Director	6907 Markel Ave.			2	1222		USA			
	ems;	ıner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Black,	Americ White,		
220	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or ftems 23a or 28a-f show snt, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	Whi	te	
5	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	ent's Usual Occup	ation during most of wo	rking	16b. Kind of Busi	ness/Ind	dustry	
V	ithin 7 ne. "an "i	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired						
7	lled w Hygier ther th	S	7 yrs. 17. Father's Name (<i>First, Middle, Last</i>)	1	S	elf Emplo		me (First, Middle,	Welde Maiden Surname)		-	
Ĕ	d be f ental h ed oi) Be	Theodore Siejack					Siminski				
<u></u>	should Me Me mark	1º	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street				tate, Zip	Code)	
Ĕ	alth a 27 is or trat		MArtin Siejack	son	690	7 Markel	Ave. Dur	ndalk Md.	21222			
ב ב	es 1 a of He fitem r othe		20a. Method of Disposition 1 ☐ Bunal 2 XCremation 3 ☐	Pomoval from State	Ob. Place of Dispo cemetery, crei	sition (Name of matory or other plac	e) July	Date 18	20c. Location - C	•		
	Pagement ant: If uny o		4 □ Donation 5 □ Other (Specific			Crematory	2	2007	Balti	more	<u> </u>	
Dalimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	nsee	d∈	Shneily F 110 Solle	üneral H rs Point	ome Of I	Oundalk 222			
	*		23a. Parth. Enter the disease, or com sheck, or heart failure. List only	plications that caused the							Approximate Interval Betv	, veen
	Physician		Immediate Cause (Final disease or condition	Δ.	laibn						Onset and D	eath
	/Medical		resulting in death)		nsequence of):	1101	action Die	1				
	Examiner	_	Sequentially list conditions,	P. COLOUR	ta t	1rtery	- Die	xesse_		\rightarrow		
Q	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	neoquenze (II).		3					
,O	execut and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of):					+		
00/00	tificate be executed g physician and as the burial-transit	edical		d								
0	tificat ng phy as th											
کر م	tth cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pr 1 Live birth 2 L	Fetal death 3	∃Ectopic pregnanc	y		23d. Date Mont			ear/
5	siclan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/N	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death 5[Other (specify) _					,	
Ċ	that the		Part II. Other significant conditions of	contributing to death but no	t resulting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco use contrib	oute to t	ne cause of d	eath?
Hecords,	uires sign	d by						1 🗆	Yes 2 No 3	B ☐ Prob	pably 4 💆	Jnknown
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N IE	lan: rtifica ctor, p	BeC	25. Was case referred to medical examiner?					eath (Check only o	•			
0 0	Physiclan: this certific ral director,	To	1 Yes 2D No		2 ER/Outpatie		4 L Nursing	-	dence 6 □Other	. ,	fy)	
	ding P J. After t funera	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Wo	ryat rk? ∣Yes 2 ∐No	28d. Describe	how injury occurred	d		
DIVISION	l or Attending after death. Director: After	icat	2 Accident investigation 3 Suicide 6 Could not b	e 290 Place of injuny	At home, farm, st		169 5 110	28f. Location (Street and Number	r or Rura	al Route Num	ıber,
2	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (S	pecify)			City or To	wn, State)			
	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		(Check only 2 Medical Example 1	nysician: To the best of my miner: On the basis of exa	y knowledge, dea amination and/or in	th occurred at the ti	me, date and plac opinion, death occ	ce, and due to the	cause(s) and man date and place, a	ner as s	stated. o the cause(s	;)
	o the ithin 2 o the o the	Medical	29b. Signature and title of certifier	one) and manner stated. 29b. Signature and title of certifier 29d. Discourse number 29d. D								
:	F3F8		153462 2/0/0									
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print) Suc	le Moi	neses.	mA	<u> </u>		
	5		7845 CAXINOC	d foad	Glen	Bornie	am c	2100	>\			
	≝ Sta Registi		31. Date filed (Month Day Year) 20	32: Registrar's	Signature	este?						
	negisti	ell		M. Carlotte	100							

	1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate	of L	Jeath		2. Date of Dea	eg. No	Sin VI VI I	3. Time of De
ian	Hugh Farce	•							July 14		2007 Year	1:38 A
ical ner	4a. Facility Name (If not institution, give				4b. City, To	own, or	Location o	f Death	oul, i		County of Deat	
	3009 Raymond Cou	rt			For	rt V	Washi	ngton	1	Pr	ince Ge	orge's
	5. Social Security Number 6. Se			ast birthday) Yrs.	If Under 1 Months	Year_ Days	If Under a	Min.	8. Date of Birth (Month, Day	Year)	Co	thplace (State or Fountry)
	418 30 6417 X]M 2□F	77	115.				V	lov 14,	192	29 Ala	bama
	10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside City L
ctor	Maryland Prince G	eorge's	For	rt Was	shingto	on						1 🗆 Yes 2
Director	10e. Street and Number				10f. Zip C	ode			1	0g. Cit	izen of What Co	ountry?
	3009 Raymond Co					2074	• •			Uni	ted Sta	
Funeral	11. Marital Status 1 □ Never Married XX Married	12. Was Decedent I Armed Forces?			Was Deceder f Yes, specify	nt of Hi y Cuba	ispanic Orig n, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)	ĺ	14. Race - Ame Black, Whit	
by F		1 ☑Yes 2 ☐ N If Yes, Give Year or Dates:	Vietn	am	1 □ Yes 2¶	VXV0	Specify:				Specify:	White
		ıcation		16a. Deced	dent's Usual	Occupa	ation			16b. K	ind of Business/	/indu <i>s</i> try
Completed	(Specify only highest grad	College (1-4or 5	i+)	life.	kind of work DO NOT use	retired	luring most }	or workin		T	E-6	
S	12			Capi	tal Po	olic					Enforc	ement
Be	17. Father's Name (First, Middle, Last)	o1+on					18. Mothe	_	(First, Middle,		Sumame)	
P				401 14 15		0			rie Lus			
ľ	19a. Informant's Name/Relationship (T) Mary Shelton (Wife									-	or Town, State, 2	
	20a. Method of Disposition	e)	20b. Pla		sition (Name natory or othe				t Washi		ocation - City or	20744 Town, State
	1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		1		natory`or oth Veter				12007		eltenha	
	21. Signature of Funeral Service Lisens		riai								nc 6633	
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dical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Hepato- Due to (or as Cirrhosi Due to (or as Hepatiti	Renal a consequence of a consequence of a consequence of the consequen	1 Synd ence of). the 1 ence of):	iver							
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by P	Part II. Other significant conditions co	ntributing to death be	ut not resul	lting in the u	nderlying cau	ise give	en in Part I.		_	oacco u		the cause of deat
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a Li									autops	V	prior to o	completion of caus
C	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes		1 🗆 Yes	2 No
0	examiner?	Hospital: 1 ☐ Inpatie	nt 2 E	R/Outpatien	t 3 DOA	Othe	ar.			W-	6 ☐Other (Spe	cifv)
L:U	27. Mariner of Death	28a. Date of Injur (Month, Day		28b. Time of		. Injury Work			8d. Describe h			
atic	2 Accident investigation	(, , , ,	,,	М		Yes 2□N	No				
Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At hon c. (Specify)	ne, farm, str	eet, factory, o	office		2	Bf. Location (Si City or Town	reet an 1, State	od Number or Ru)	ural Route Number
edicai C	29a Certifier 1 Certifying Phy (Check only one)	sician: To the heal iner: On the basis of and manner sta	examination	nedga daut on and/or inv	consurred at vestigation, in	the tim	ia date and pinion, deat	f place, as h occurre	nd dua to the c d at the time, d	tusa(s) ate and	and manner as d place, and due	stated to the cause(s)
Me	29b. Signature and little of certifier	/			29c. l	License	number		2	9d. Da	te signed (Monti	h, Day, Year)
	1 the	lamar -	7	Mo	01	012	38425			Jii	ly 17, 2	2007
1		ompleted cause of d	eath (Item :	4						Ju	_, _, ,	20762
	30. Name an state of person who co											

		For State Registrar	State of Mary		artment of <i>rtificate c</i>				giene Reg. No. 🥖	007	23344
		Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Voor	3. Time of Death
Physi		Burnla Conde						July 3		Year 07	8:15 AM
/Med Exam		Frank Sandy 4a. Facility Name (If not institution, give s	street and number)		4b. City, Town	n, or Location	of Death		4c. County of Death		
LAGIN	iiiei	Casey House				Derw	rood		Mon	tgome	ry
Funera	1	5. Social Security Number 6. Sex		yrs. last birthday,	If Under 1 Ye		r 24 Hrs. Min.	8. Date of Birt (Month, Da	h Vearl	9. Birth	place (State or Foreign intry)
Directo		217-16-0306	M 2□F	88 Yrs.	Months Da	ys Hours	IVIII I.	12/15			ngary
ъ	-	Usual Residence of Decedent									
yland		10a. State 10b. County	10	c. City, Town or L	ocation						10d. Inside City Limits
Mar I-f st	ģ	MD Montgome	erv	Silver	Spring						1 ☐ Yes 2 No
r 28a	Director	10e. Street and Number			10f. Zip Cod	le			10g. Citizen	of What Cou	intry?
3a o		3829 Ferrara Dr.			2090	06-			USA		
death ms 2	Funeral		12. Was Decedent Ever	in U.S. 13.	Was Decedent	of Hispanic O	rigin? (Spe	ecify Yes or No	. 14. 1	Race - Amer Black, White	
of the siner	Ē	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 📶			riicari, etc./			, etc.
urs a ali, o	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		I⊟ Yes Zpan	No Specify	6		Spe	ecify: Ca	ucasian
21215-0036 d within 72 hours af giene. er than "natural", or , the Medical Exam	te d	15. Decedent's Edu	cation	16a. Dece	edent's Usual Oc e kind of work do	cupation	et of work	ina	16b. Kind o	f Business/I	ndustry
Pin 7	음	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)	01 01 110111	9	US A	ir Fo	rce
T the the	Į.		1	Mas	ter Sar	geant					
othe yeart,	Be	17. Father's Name (First, Middle, Last)				18. Moth	ner's Name	e (First, Middle,	Maiden Sur	name)	
land be lend a rectangle of th	일	Alajos Sandy				Ma	rgare	t Bizja	ık		
Maryland d 2 should be file th and Mental Hy ty Is marked oth traumatic event	-	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mail	ling Address (Str	eet and Numi	ber or Run	al Route Numb	er, City or To	wn, State, Z	ip Code)
M 2 nd 2 lith a 27 ls		Juana Sandy/Wife		382	9 Ferra	ra Dr.	Silv	er Spr	ing, M	D 2090	06-
of Heg		20a. Method of Disposition		20b. Place of Disp	osition (Name o	f place)	[Date	20c. Locati	on - City or	Fown, State
no ages	10	1 ☐ Burial 2 ☑ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)			eake Cre			Jul 18 2007	Belt	sville	, Maryland
Baltimore, Department of Hee Important: If item any injury or othe	•£l	21. Signature of Funeral Service Licens	22. Name and Ad	dress of Faci	lity						
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	200	23a. Part1. Enter the disease, or compl	main	382	933 Gis	t Ave.	Silv	ation Se er Spri	ıg, Mar	yland	20910-
bhysiciae executed Examine physician and physiciae and physiciae and sthe burial-transit	d	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
that the death certificat ed by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1□Live birth 2 [4□Pregnant at tirn 9□Unknown	Fetal death 3	□Ectopic pregn				23d	. Date of deli	ivery Day Year
cords, P. w requires that is been signed by should be detail	b	Part II. Other significant conditions co Coronary Artery D		ot resulting in the	underlying cause	e given in Par	t I.				the cause of death?
e la has	Completed	_A-Fib						24a. Was auto perfe			topsy findings available completion of cause of
	a)	25. Was case referred to medical				26. Pla	ce of Deal	th (Check only			
or Vita Physiclan: this certific ral director,	100	avaminar?	Hospital: 1 ☐ Inpatient	2 ER/Outpati	ent 3 DOA	Other				Other (Sne	city) HOSPICE
O Physical displaying the strange of	P. :	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c.	Injury at Work?		28d. Describe		*	1037.100
On ding	향	Natural 5 Pending investigation	(Month, Day Y	ear) Injury	M	Work? 1 ☐ Yes 2[□No				
Division or a tending Phy after death. I Director: After this din by the funeral d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (- At home, farm, s Specify)	street, factory, of	fice		28f. Location (City or To	Street and N wn, State)	lumber or Ru	ural Route Number,
Hospita Hospita Hours Funeral	Medical C	29a. Certifier (Check only one)	rsiclan: To the best of r Iner: On the basis of ex and manner stated	amination end/or	ath occurred at t investigation, in	he time, date my opinion, d	and place leath occu	, and due to the	cause(s) an , date and pl	d manner as ace, and due	s stated. e to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	1 00	/	29c. Li	cense numbe	r		29d. Date s	igned (Mont	h, Day, Year)
⊢ ≯ ⊢ ŏ		Dugiana h	hollow &	(5 mi)	1)	0064	615		07-	16-200	07
ILVI		30. Name and address of person who co									
144		Genevieve A. Wrob				(i11 RA	. Ro	ckville	MD 20	855	
V '	State	31. Date filed (Month, Day, Year)	32. Registrar's		CUDUCE I						
	State		2007	Le	1 0	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 6:45 AM July 15, 2007 /Medical Virginia Jean Saunders 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Nursing Home Montgomery Rockville If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreigr Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F 72 Director 220-56-5814 09/07/1934 Trinidad Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10h. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20876-Trindad 11706 Rose Arbor Ct. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or itee 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify. Completed by 3 Nidowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medicine Elementary/Secondary (0-12) College (1-4or 5+) Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Bernard McDonald Layne ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Roderick Saunders/Son 11706 Rose Arbor Germantown, MD 20876-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or oth 1 ☐ Burial 2 图 Cremation 3 ☐ Removal from State Jul 19 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 2007 Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral MO0382 Stylled Johnson Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause trisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as t IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year jo in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Intracranial Hemorrhage 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dementia 24a. Was an autopsy performed? Yes 2 No has 1 Yes Parkinsons Disease 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death.

I Director: A
id in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

within 24 hours are.

To the Funeral Dir

State Registrar

(Check on

29b. Signature and title of certifier

Ravi Passi MD 15225 Shady Grove Rd #208 Rockville MD 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 2 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28656

29d. Date signed (Month, Day, Year)

07-15-2007

			For State Registrar	State of Maryland	d / Department of Health and I Certificate of Death	Mental Hygien	2 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Physici		1. Decedent's Name (First, Middle, Las	CUFFUOLES		2. Date of Death	Day Year 3. Time of Death
57	/Medic Examir Funeral		4a. Facility Name (If not institution, give	PRING ROE	ast birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
19/67	Director			□M 384 P8	Yrs. Months Days Hours Min.	OSE 33	938 RHOOF ISLAW
, Cuc	the Maryland 28e-f show colline	ector	10a. State 10b. County (County Charles	10c. City	r, Town or Location	10. 6	10d. Inside City ⊔mits 1 ☐ Yes ﷺ No
745 F	5-0036 72 hours after death with the Maryland 72 hours after death with the Maryland "natural", or Items 23s or 28e-f show idical Examiner must be notified at	Funeral Director	10e. Street and Number WT 08 Silvar S 11. Marital Status	12. Was Decedent Ever in U.	3.\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Citizen of What Country? U.S.A
F	5-0036 72 hours after natural; or ite	by	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes No If Yes, Give Year or Dates:	1 ☐ Yes 🏂 No Specify:	o Rican, etc.)	Specify: WHITE
		Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16b.	Kind of Business/Industry
WOIF	Maryland 2 d 2 should be filed th and Mental Hygi 27 is marked other traumatic event,	To Be Co	17. Father's Name (First, Middle, Last)	2. noznko	18. Mother's Nan	ne (First, Middle, Maide	an Symame)
	or Heal		19a. Informant's Name/Relationship (7) 20a. Method of Disposition 15€ Burial 2 □ Cremation 3 □	E SR. 206. P	19b. Mailing Address (Street and Number or Rulace of Disposition (Name of emetery, crematory or other place)	ROPO PERR	Location - City or Town, State
Ma	Baltimore, permit. Pages 1 ar Department of Hea Important: if Item eny injury or othe		4 Donation 5 Other (Specify 21. Sign turn Funera S vice to n	see	22. Name and Address of Facility AC	EL PROPRETO	JETON SIFORD STORY
	Physician /Medical		23a. Part1. Enter the disease, or cont shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. Due to (or as a consequ	n. Do not enter the mode of dying, such as cardiac CHIC COLON CON uence of):		Approximate Interval Between Onser and Death
	5 be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)			/
	68760, Tificate be ex ng physicien as the buria	edicai	(d.			
1	P.O. BOX 65 that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	dS, P	ğ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
!	al Record The law requir cate has been s page 2 should	Completed				24a. Was an autopsy performed?	
	DIVISION Of VITAL RECORDS, P.O. BOX 68/60, for Attending Physicien: The law requires that the death certificate be executed after cleath. Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit	tlon: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	26. Place of Dea ER/Outpatient 3 DOA Other: 4 Nursing H 28b. Time of Injury Work? M 1 Yes 2 No	ome 5 Residence 28d. Describe how in	6 □Other (Specify) ury occurred
	DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, larm, street, lactory, office	28I. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowing. iner: On the basis of examination and manner stated.	wledge, death occurred at the time, date and place tion and/or investigation, in my opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
•	To the within 2 To the complet	M	29b. Signature and title of certifier	Huche !	29c. License number D36814	29d. [Date signed (Month, Day, Year)
-	51		Sichard Little	completed cause of death (16)	23a) (Type, Print) 60605 ler Dr. Sc	LITE 302	Towson MD 21204
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrat's Signa	ture the Apartie		

State of Maryland / Department of Health and Ment	tal Hygiene	
Certificate of Death	Reg. No.	7

Physician	
/Medical	
Examiner	

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and bompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	1. Decedent's Name		2. Date of De Month		na.	V	3. Time of Deat	n							
n	John Fr	anklin W	heeler, Jr	_								17, 2007 Year 12:12			o M
il ir			e street and number)	•								4c. County of Death			
٧.	SAINT JO	SEPH MED	ICAL CENTE	R		TOWSON						BALTI	MORE		
	5. Social Security N			t birthday)	if Under		If Under		8. Date of Bi	rth	- "	9. Birthr	place (State or For	eign	
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	Usual Residence of									prii	,	1710			
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<u>e</u>	10e. Street and Nur		THOTE			10f. Zip					10g. (0g. Citizen of What Country?			
by Funeral Directo	3917 Mi	ller Roa	đ					21087	,			U. S	Λ		
je i	11. Marital Status	TICI ROA	12. Was Decedent B	ver in U.S.	13. V	Vas Dece				ecify Yes or No Rican, etc.)	0-	14. Rac	e - Americ	ean Indian,	
Ē		ied 2 Married	Armed Forces? 1 ☑ Yes 2 □ N		_					Rican, etc.)		Blac	k, White,	etc.	
2	3 🗌 Widowed	44	If Yes, Give Year or Dates:	1947	1	□Yes	2 X No	Specify:				Specify	Whi	ite	
9	(0	15. Decedent's E	ducation		16a. Deced	ent's Usua	al Occupa	ation	1 - 6 1		16b.	. Kind of Bu	siness/In	dustry	
be	Elementary/Seco	oify only highest grandary (0-12)	College (1-4or 5	+)	life. E	OO NOT us	rk done d se retired	luring mos)	i or worki	ng					
Be Completed		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4	.,	Ac	lmini	stra	tor				Ba1t	imor	e County	
9	17. Father's Name ((First, Middle, Last)					18. Mothe	er's Name	(First, Middle	, Maid	len Surnam	ie)		
0	John F.	Wheeler,	Sr.					Fr	ance	s Este	11a	Thom	nson		
	19a. Informant's Na				19b. Mailin	g Address	(Street a			al Route Numb				Code)	
	Mary C.	Wheeler	(Wife)		3917	Mi11	er R	oad.	King	sville	. M	arv1a	nd 2	1087	
	20a. Method of Disp		(20b. Plac	ce of Dispos netery, cren	sition (Nar	ne of	7		Date	_	Location -			
		☐ Cremation 3 ☐ 5 ☐ Other (<i>Specil</i>	Removal from State	St.	Micha	aeI L	uthe	rani	7/20	12007	n -	1 4 4	1	W1	
	21. Sigrature of Fu			LChui	cch Ce	e me te . Name ar	ry nd Addres	s of Facilit)// <u>/</u> _U	1/ 200 /	_ba	Trimo	re, I	<u>Maryland</u>	
	tap	auc	Rine	Re							ek Funeral Home Inc. more, Maryland 21236				
	23a. Part1. Enter th	he disease, or com	plications that caused	the death.								-		Approximate Interval Between	
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ت ق	Sequentially list con if any, leading to im	nditions, nmediate	b. SEPTIC Due to (or as												
Examiner	cause. Enter Unde Cause (Disease or that initiated events	erlying injury	c BOWEL C	ווקדפוו	CTION										
xa	resulting in death) L	Last	Due to (or as												
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cian/Medical	IF FEMALE: 23b. Was decedent	t progpant	23c. If yes, outcome									23d. Dat	te of delive	erv	
Cial Cial	in the past 12	months?	1□Live birth 4□Pregnant at			Ectopic pi Other <i>(</i> sp							nth	Day Year	
Physi	9 ☐ Unknown		9□Unknown												
			contributing to death bu	ıt not resulti	ng in the un	derlying c	ause give	n in Part I		23e. Did	tobacc	o use cont	ribute to t	he cause of death	?
<u>D</u>	CONGEST	IVE CARD	LOMYOPATHY							1 🗆	Yes	2 % No	3 ☐ Prol	bably 4 □Unkno	own
ete	COAGULO	PATHY								24a. Was	an.	24h 1	Moro auto	nev findinge availe	ahle.
Completed by			TTON							auto	psy ormed	2 240.	prior to co death?	opsy findings availa impletion of cause	of
		FIBRILLA'	LIUN							1□ Yes	2		1 □Yes	2 No	
å	25. Was case referred to medical examiner?														
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0	1 Natural	5 Pending	(Month, Day		Injury		28c. Injury Work			Zod. Describe	HOW II	ijury occuri	eu		
cat	2 Accident Investigation Accident Investigation M 1 Yes 2 No										al Pouta Number				
	3 Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number or Bural Route Number or Rural								ar noute ivaniber,						
<u>ತ</u>	29a, Certifier	1 Certifying Pi	nysician: To the best of	of my knowle	edne death	nccurred	at the tin	ne date er	nd place	and due to the	Called	e(s) and me	anner ac c	stated	-
edical Certification:	(Check only one)		miner: On the basis of and manner sta	examinatio											
Me	29b. Signature and	title of certifier	and mornior dec		WC	290	c. License	number			29 d.	Date signe	d (Month.	Day, Year)	_
	172	()	1 (15	the	rvv.							1-17			
	30 Name and add	ross of norsen who	completed cause of d	agth (Item ?	3a) /Tuno !		03182	26				- ' '		1	
- 1	UV. I VAITIE ATTU AUUT	and or herson Muo	completed cause of di	- MILL / ILCIII Z	ua, (1 ype, 1	mitj									

State

Registrar

RICHARD L.

31. Date filed (Month, Day, Year)

JUL

LINTHICUM

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M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** :55PM 2007 44 ROSETTA WALKER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GENESIS AT LOCH RAVEN BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🕅 F Yrs. Director 79 JUNE 22 TENNESSEE 352-26-7791 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director HARFORD CO ABERDEEN MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 518 BALTIMORE COURT 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygie. Important: if Item 27 is marked other it eny injury or other traumatic event, Iffa once. HOUSEWIFE N/A 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STEVEN GARDNER OPHELIA GARDNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julian A. Walker 518 Baltimore Ct., Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARFORD MEMORIAL 07-20-07 ABERDEEN, MARYLAND 21. Signature J.F. ral/S 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. wur 321 S PHILA. BLVD., ABERDEEN, MD 21001 23a. Part 1. Senter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 100 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of ettending physicien end for use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 1 No 2) No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospital or Attanding within 24 hours after death.

To the Funeref Director: After completely filled in by the fun 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 1 29b. Signatuyé and title of certifier 29c_License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . 4202 01 31. Date filed (Month, Day, Year) gistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

JUL 2 0 2007

, Rose7

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5, perFH, G870, 8/6/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Wilson **Physician** Madison Aleese コー1. 13 2007 1330 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Buttiner Baltimore Hospital OLLINS JOHNS If Under 1 Year If Under 24 Hrs
Months Days Hours Min.
O 15 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F 6-28-2007 215-79-0936 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Baltimore Baltimore 1 Yes 2 No MÛ. **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Woodcrest 0 21209 USA 6004 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iten dical Examiner Black White etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **N**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 27 Is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bianca InKnown ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wilson (Mother) 6004 Woodcrest Are. Important: If item 27 is any injury or other train once. Bignea Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of H Pikesville, MO.
119 S. Stricker st. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Ridge 7-16-2007 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Compossion Funeral Services, P.A. Baltimore, MD. 21223 M01401 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, if heart failure. List only one cause on each line. Immediate Cause (Final Cerebral 15days **Physician** disease or condition resulting in death) Coma /Medical Due to (or as a consequence of): 15 days Examiner non ketotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 👺 No Month Dav Year 4□Pregnant at time of death 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? page 1∐ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 The patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√10 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Il Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) R95-000 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 21230 600 North Street Paul Mithach Wolle MO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** William John Richard Woodley July 16, 2007 2:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7503 Wyndale Rd. Chevy Chase Montgomery if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F 215-48-6577 83 Director 18, 1923 Canada Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ms 23a or 28a-f shor must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7503 Wyndale Rd. 20815 death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status "natural", or item edical Examiner r Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical International Monetary than " Elementary/Secondary (0-12) College (1-4or 5+) Economist Fund 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence A. Woodley Daisy Mae Schleuter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. Mendelle T. Woodley/wife 7503 Wyndale Rd., Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition July 18, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland Crematorium, Inc. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of uneral Service Licensee M01346 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Huntington's Chorea disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy rector, page performed? Yes 2 💢 No 1□ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2X No this 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, nours after death.

neral Director: / To the Hospital within 24 hours at To the Funeral C

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

2007 S. Com

29d. Date signed (Month, Day, Year)

July 17, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Thomas L. Sacks, M.D., 3301 New Mexico Ave., N.W. #350, Washington, D.C. 20016

11. Date filed (Month, Pay, Year) 2007 Registrar's Signature

1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DC12568

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician 2007 19 0107 July. Margaret E. White /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F 79 Washington, D.C Director 1928 577-32-2969 January 1, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show Items 23a or 28a-f shov ner must be notifled at 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1619 Lewis Avenue 20851 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: þ White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ligon Smith Mary Elizabeth Westcamp 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Longwood Drive, Rockville, Maryland 20850 Evelyn McClung / Daughter July 2007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee Rockville, Rockville, M01473 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failur. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Years Cardiovascular Atherosclerotic Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 🖾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Injury 1 ဩ≀Natural 1 ☐ Yes 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide in 24 hours the Funeral Dire 29a. Certifier 1 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) licia J. Mistry MD July 19, 2007 D59738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 9901 Medical Center Drive, Rockville, Maryland 20850 Alicia Mistry, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 0 Registrar 2007

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar		•	Cei	rtificate of	Death		Reg. N	L U U /	
2.	Physici	an	1. Decedent's Name (First, Middle, La	,	-				2. Date Mont	of Death	ay Year	3. Time of Death
	/Medic		Erma Gertrude Wel						Ju	LY 1	6 200	
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town, o				c. County of Dea	th
			5. Social Security Number 6. S	HUSPITAL.		st birthday)	If Under 1 Year		IMORE A Date	- 1	Q Rin	hplace (State or Foreign
2	Funeral Director			1 □ M 2 X) F	92	Yrs.	Months Days	Hours	Min. (Mon	of Birth h, Day, Yea 23 ,	1915 Min	ountry)
	land ow		10a. State 10b. County	1	10c. City,	Town or Lo	cation					10d. Inside City Limits
	A-f sh iffed	to	Maryland Montgome	ry	Beth	iesda						1 ∐Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. C	citizen of What Co	puntry?
	ath w	la l	5604 Forest Place				2081				ted Stat	
	ter de	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		. 13.	Was Decedent of H If Yes, specify Cub	lispanic Orig an, Mexican,	in? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Ame Black, Whit	
39	within 72 hours after death with the Maryland tene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:	If Yes, Give 1			1 ☐ Yes 21 No Specify:				ite
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21	ithin 7 ne. nan "i Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	life.	kind of work done DO NOT use retired	d)	or working			
12	lled w tygier her th		17. Father's Name (First, Middle, Last	4		Homem	aker	10 Mather	in Name (First 8)		n Home	
and	d be findal Head of	Be	Frank L. Gorenflo	•				_	's Name <i>(First, M</i> : Hurley	іааів, маіав	en Surname)	
I Y	shoul nd Me mark imath	ဥ	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street			lumber, City	or Town, State,	Zip Code)
Ž	alth a 27 Is 27 Is sr trau		Frank Michael Wel	.sh/Son			Forest P					, ,
ore,	of He of He ritem		20a. Method of Disposition 1 ☐ Burial 2X1 Cremation 3 ☐	TD	20b. Pla	ice of Dispo	sition (Name of	ce)	Date		Location - City or	Town, State
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Special	fy)	Mont	gomer	y um. Inc.	ال	July 20, 2007	Bet	hesda, M	aryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euneral Service Lice	1see	M013	846 Be	2. Name and Addre thesda-Cl	ss of Facility hevy C	Robert A	Pum ic. 75	phrey Fu 57 Wisco	neral Home/ nsin Avenue
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th	ne death.							Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	PUE		AIN					9	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):									
H	Lxammer	_	Sequentially list conditions,				HOCYTE C	LEI	IKEME A	4		1 YEAR
J	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a t	conseque	nice oi).						
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89	ng ph as th	Medical	IF FEMALE:			_						-
Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1☐Live birth 2	Fetal	death 3	Ectopic pregnancy	y			23d. Date of de Month	livery Day Year
O.	the de	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at tir 9□Unknown	me of dea	ath 5L	Other (specify)			-		
σ.	that the by detac		Part II. Other significant conditions	contributing to death but	not result	ing in the u	nderlying cause giv	en in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
rds	quires n sign ald be	d by					*			1 🗌 Yes	2 No 3 P	robably 4 Hunknown
Vital Records, P.	aw requir s been si 2 should	Completed							24a.	Was an	24b. Were a	utopsy findings available
ž	nysician: The law his certificate has I I director, page 2 s	mo								autopsy performed? Yes 2	prior to death?	completion of cause of 2 ☐ No
/ita	ctor,	Be	25. Was case referred to medical examiner?					26. Place	of Death (Check			
<u></u>	hysle this o	은	1 ☐ Yes 2 ☐ No				t 3□ DOA Oth	4 LI NUI:			6 ☐Other (Spe	cify)
Division or \	tending Ph leath. tor: After th the funeral	ion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y		28b. Time of Injury	Wor	yat k? Yes 2 ∐ N		cribe how inj	ury occurred	
ISIC	or Attending after death. Director: After in by the funer	Certification:	3 Suicide 6 □ Could not b	e 290 Place of injury	/ - At hom	ne, farm, str		res ZUN		ion (Street	and Number or R	ural Route Number,
2	pltal or / ours after eral Dire	ertii	4 ☐ Homicide determined	building, etc. ((Specify)					or Town, Sta		
	Fun 4 hc	edica! C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of a miner: On the basis of ea and manner state	xaminatio	ledge, death on and/or in	n occurred at the til vestigation, in my o	me, date and opinion, deat	d place, and due t h occurred at the	o the cause time, date a	(s) and manner a	s stated. e to the cause(s)
	To the Hos within 24 hd To the Fun completely	Med	29b. Signature and title of certifier	and manner state	Ju.		29c. Licens	e number		29d. C	ate signed (Mon	th, Day, Year)
	⊢ s ⊢ ō			W.D.			ρ_	186	13-	1		6,2007.
•		ŀ	30. Name and address of person who		th (Item 2	23a) (Type,	Print)					,
	ſυ			HIM, M.D. C			TONAVE.	BACTI	MORE,	MD.	21227.	
g), y	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. Filigistrar's	s Signatu	N A	sale					

WELSH, ERMA G.

		For State Registrar Amen			G869,	7/30/07 9	ntificate of	Death	2. Date of De	Reg. No.	201		3. Time of Death
Physici	_	1. Decedent's Name (Fi		,	. 1				Month July 1	Day	07	Year	12:08 a M
/Medic		4a, Facility Name (If not		e Yarche			4b. City, Town, o	or Location of De			. County of	f Death	12:00 a
Examin	ier	Stella Ma:					Timon			Ва	Baltimore		
Funeral Director		5. Social Security Numb 218-46-588	per 6.	Sex 1 □ M 2 🛣 F	7. Age (In	yrs. last birthday, Yrs.) If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year)		Coui	place (State or Foreig ntry) 11and
show	Ļ		b. County		10	c. City, Town or L							10d. Inside City Limits
28a-f	ecto	MD 10e, Street and Number	Balti	more		Ti	monium 10f. Zip Code			10a. Cit	tizen of Wh	hat Cou	ntry?
a or i	宣	2300 Dula		llev Ro	ad		2109	3		_	JSA		,
Department or result and wenter hyperies important; if item 27 is marked other than "natural"; or items 23a or 28a-f show important: if item 27 is marked other than "natural"; or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 12. Was Decede Armed Force 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Poivorced			cedent Ever forces? 2 X No live	r in U.S. 13.	. Was Decedent of If Yes, specify Cut	(Specify Yes or No erto Rican, etc.))-		, White,		
an "natura Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				I (Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of v	vorking	16b. K	(ind of Bus	siness/In	ndustry
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ris marked other t	Be	17. Father's Name (Firs		st)					lame (First, Middle	, ivialuer	i Surriame	3)	
narke	٩	Joseph Ya 19a. Informant's Name		(Type Print)		19h Mail	ling Address (Stree	t and Number or	ia Lippa Rural Route Numl	per, City	or Town, S	State, Zi	p Code)
27 is r traur		Gloria Bar	•			1702	A Bonnet	t Place	Bel Air	, MD	2101	5	
Department of Health important: If Item 27 is any injury or other tra		20a. Method of Disposit 1 □ Burial 2 □ C 4 □ Donation 5 [Cremation 3		n State	0aklawn	position (Name of ematory or other place) Cemetery	7 7/	Date 19/2007	Balt	timor	e, l	own, State Maryland
importar importar any injur once.		21. Signature of Funer					22. Name and Addr	ess of Facility	Miller-D	ppe.	l Fun	era.	1 Home
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 1:55A.M 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F Hours 182-16-4872 Director vanic Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show must be notified at 1 ☐ Yes 2 No Director TIMOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 □ Divorced Whit Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any Injury or other traumatic event, the ones. ean stress 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be Kowski 1)a ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition TIAL MORE 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License BALTIMORE, MD 2123 Evens Funcial Chapel Cremotion Service TOLK 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death cation that caus in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each ine. Immediate Cause (Final disease or condition resulting in death) Physician UD YEXKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Po Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Vemente 24a. Was an Tas autopsy performed' certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Yes 2 No P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/20/07 31295

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State Registrar WENDY KLOSSEMO 4701 N CAMACES ST
31. Date filed (Month, Day, Year)
32. Registrar's Signature

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JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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7-05384 yan Young		State of Maryland	/ Depai	rtment of	Health a	nd Menta	al Hygiene	gible.	07 .000
, ,	R	- For State		tificate of				Reg. No.	
Physiciar	1/	Decedent's Name (First, Middle,Last)					Date of De Month	eath Day Year	3. Time of Death 0632 hrs
Medical Examine		Ryan Collins McKinnley Ela 4a. Facility Name (If not institution, give street and number			4b. City. Town,	or Location of	Month July 14,	4c. County of D	
		University Hospital	,		Baltimore				N/A
Funeral			ge (In yrs. la		If Under 1 Y			Birth(MM/DD/YYYY) 9	Birthplace (State or preign Baltimore,
Director		217-96-6672 1×M 2 F	26	Yrs		ays Hours	Min. Jan.(07,1981	Country) Maryland
		Usual Residence of Decedent 10a. State 10b. County	Inc. City	Town or Locati	ion				10d. Inside City Limits
ow any		Maryland N/A		timore	1011				1 X Yes 2 No
Maryland 28a-f show d at once.	ōL	10e. Street and Number	<u> </u>		10f. Zip Code	e		10g. Citizen of What	Country?
with the Maryland ns 23a or 28a-f sho be notified at once.		4652 Marble Hill Road			2	1239		United S	tates
ms 23.	ఠ	11. Marital Status 12. Was Deceden Armed Forces		S. 13. Wa	is Decedent of	Hispanic Origi	n? (Specify Yes or I Puerto Rican, etc.)	No- 14. Race - A White, e	merican Indian, Black, tc.
r death	Funeral	1 Zinever Married 2 Married 1 Yes 2	X No		Yes 2 X		, ,	Specify:	Black
5-0036 led within 72 hours afte Hygien other than "natural", the Medical Examiner	اھ	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade co	mpleted)				ind of work done	16b. Kind of Busin	ess/Industry
72 hou n "nat	Completed	Elementary/Secondary (0-12) College (1-4 or		during m	ost of working		use retired)	Q1	·
vithin ene er tha	립	12 01			Studen				udent
215-C be filed val Hygi ked oth		17. Father's Name (First, Middle, Last) Collins McKinnley Elam, Jr.					J. Young	e, Maiden Surname)	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she naife event, the Medical Extensiner must be notified at once	To Be	19a. Informant's Name/Relationship (Type, Print)				treet and Numl	ber or Rural Route N	lumber, City or Town,	
MD id 2 sho lith and in 27 is aumatic		Mrs. Ruby J. Young (Mother		1					yland 21239
re, S I an of Hea If itel		20a. Method of Disposition 1	20b. F	Place of Dispos	sition (Name of	cemetery,	July 20,	20c. Location - Ci	ty or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	- 1	4 Donation 5 Other Specify:	LLOU				2007		re,Maryland
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Licensee		Pe	aceful 25 Vork	Altern	atives Fu	neral&Crem	ation Ctr.,P.7 21093
Physician	\dashv	23a. Palt I Enter the disease, or complications that cause failure. List only one cause on each line.	d the death.	. Do not enter t	the mode of dy	ing, such as ca	ardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease a. Head and Nec	k Injuries						Death
ZXdIIIIIei		or condition resulting in death) Due to (or as a con	sequence o	f):					
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Box 68760, e death certificate be the attending physici the attending physici ed for use as the buri	₩.	IF FEMALE: 23c. If yes, outcome of the second of the secon	ome of preg		etal death	3 Ectopic	pregnancy	23d. Date of de	elivery Day Year
Sox 687 leath certific e attending	iciar	past 12 months?	at time of de		ther (Specify)				
Bo he deat	lys S	Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to dea	ath but not r	esulting in the	underlying cau	se given in Pa	rt I 23e. Di	d tobacco use contribu	ute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	اھ	Part II. Other significant conditions	atii Dat Hot i	coditing in the	andonying caa	30 givo			Probably 4 Unknown
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e law te has ge 2 sh	Completed						pe	erformed? dea	ath? Yes 2 No
tal Rection: The certificate ector, page	BeC	25. Was case referred to medical			26.P		(Check only one)		
Vit;	ToB	1 V Yes 2 No		ER/Outpatien		Other ₄	Nursing Home 5	Residence 6 be how injury occurred	Other:
n of ding Pl		27. Manner of Death 1 Natural 5 Pending 28a. Date of Ir	njury /Year) /	28b. Time of 0515 hrs	injury 28c.	Injury at Work Yes 2 ✓	Driver au	to fixed object co	
Sio	cati	2 Accident Investigation 28e. Place of	Injury - At h	ome, farm, stre	eet, factory, offi			n (Street and Number	or Rural Route Number, City
Div ital or urs afte	Certification:	3 Suicide 6 Could not be determined (Specify)	ocal Stre	et			or Tow 2200 West	n, State) t Northern Parkway,	Baltimore, Md.
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn.		29a. Certifier 1 Certifying Physician: To the best of	my knowled	lge, death occu	urred at the tim	e, date and pla	ace, and due to the c	ause(s) and manner a	s stated.
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examiner and manner state				cense number	ouried at the time, 0		(Month, Day, Year)
• ~	2	29b. Signature and title of certifier	27			.C.M.E.		July 15, 200	
		30. Name and address of person who completed cause o	f death (Iten	n 23a)					
0		Ling Li, MD Assistant Medical Examin	er 111	Penn Stre	et, Baltimo	re, MD 212	201		
	ate	31. Date filed (Month, Day, Year) 32. Regis	ar's Signat	ure	Crost 1				
Regist	للقت	111 2 1 /111/ 33	30 P 10 P	At A	Chicago . Organ				

DHMR 17 Rev 1/2001 OCME 2006

OCME

OCME

ORIGINAL

			For State Registrar	State of Mary		artment of H <i>rtificate of l</i>		, ,	ne . No.		. ,
			Decedent's Name (First, Middle, Last)					2. Date of Death	Em to	1 1	3. Time of Death
	Physicia Medic/		Betty Lee Zelle	er				Month July	17, 2	Year 007	11:40 A M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
			Gilchrist Center		altimore		Baltimore				
	Funeral		5. Social Security Number 6. Sex	7. Age (1.	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear)	9. Birthp	place (State or Foreign ntry)
	Director		219-28-2377	78	3 Yrs.			May 30,	1929	Ma	aryland
	and and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Maryl f sho	jo	Maryland N/A		r	Baltimore					1 X Yes 2 □ No
	the 28a-	Director	10e. Street and Number		I	10f. Zip Code		100	. Citizen of V	Nhat Cour	ntry?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at		3307 Northway Driv	7.0		21	234		TT	S. A.	
	ms 2	Funeral		12. Was Decedent Eve	r in U.S. 13.	Was Decedent of H		ecify Yes or No-	14. Rac	e - Americ	can Indian,
9	after or ite		1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	1 ☐ Yes 2X No	Specify:	Hican, etc.)		k, White,	etc.
8	ral", Exar	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		TET TES ZALINO	эреспу.		Specify	Whi	te
21215-0036	72 h 'natu dical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	ing 16	Bb. Kind of Bu	usiness/In	dustry
12	vithin ne. han '	d d	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.				_		
	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)			Homema		e (First, Middle, Ma		Home	2
au	d be and a sed o) Be	Charles E. Law					ha Wilhe		,0)	
Maryland	shoul od Me mark	ှင	19a. Informant's Name/Relationship (Type	oe. Print)	19b. Maili	ng Address (Street				State. Zic	Code)
	nd 2:		William C. Zeller	(Spouse)	3307	Northway	Drive. F	Raltimore	Marv	1and	21234
ē,	item othe		20a. Method of Disposition		20b. Place of Dispo				c. Location -		
E	Page nent c nt: If		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Oaklawn (i	./2007 Ba	altimo	re. N	Marvland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature	×2		2. Name and Addres					
<u>m</u>	<u>8 3 E 6 8</u>	V 10	All Tella		9	705 Belai	r Road, E	Baltimore	, Mary	1and	21236
T,			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the ne cause on each line.	e death. Do not en	ter the mode of dyin	ig, such as cardiac	or respiratory arres	t,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	Bre	ast Co	ancer					Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a c		- II					7
	Lxammer	<u>.</u>	Sequentially list conditions,	Due to for so a	ones (100 of);						
	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Et al. Userning. Cause (Disease or injury	Due to (or as a c	onsequence on.	equence of):					
	execu al-trai	Examiner	that initiated events cresulting in death) Last	Due to (or as a c	onsequence of):	<u> </u>				-	
68760,	icate be executed physician and s the burial-transit	dical		I.							
	4 5										
Вох	death certific e attending p d for use as t	N/us	23b. was decedent pregnant	3c. If yes, outcome pf 1 ☐ Live birth 2 [☐Ectopic pregnancy	,			te of deliv	•
	0 0	sici	in the past 12 months? 1 ☐ Yes 2 7 No	4□Pregnant at tim		Other (specify)			Mo	onth	Day Year
P.0	that the de ned by the a detached t	Physician/M	9 Unknown				i- D-41	OO+ Dida-b-		1-11- A - A - A	he cause of death?
S,	96 FB 90	by	Part II. Other significant conditions cor	unbuting to death but i	iot resulting in the t	indenying cause giv	en in Part i.		2 □ No	3 ☐ Proi	
Records,	w requir been si should b	Completed						-			
3ec	has the	mple						24a. Was an autopsy performe		Were auto prior to co death?	opsy findings available impletion of cause of
	The ate	_	05 114 11 11					1□ Yes 2	No No		2 No
or Vital		o Be	25. Was case referred to medical examiner?	lospital:	2□ER/Outpotio	mt all DOA Oth	or.	th (Check only one)			1000000
ō			1 Yes 2 No 1 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie			ome 5 Residen 28d. Describe how		ner <i>(Speci</i> i red	W) VW) SPICE
on	Attending r death. ector: After by the fune	tior	Natural 5 ☐ Pending investigation	(Month, Day Y	ear) Injury		k? Yes 2 ☐ No				
Division	Atte er dea ecto by th	ifice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (- At home, farm, st	reet, factory, office		28f. Location (Stre City or Town,		ber or Run	al Route Number,
ō	tal or s afte al Dir ed n	Certification:		building, oto. (opecny)			Ony or Town,	Siale)		
	Hospital 24 hours a Funeral tely filled		(Check only 2 Medical Exami	sician: To the best of r	amination and/or in						
	To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the	29a. Certifier (Check only one) 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (//									
	1 × 0 0	-	29b. Signature and title of certifier	Pro		T)	CB30	2 290	Date signe	17	2007
,	Y		30. Name and address of person who co	umpleted source of disconnected	h (Itom 00a) (Ta	Print)	30 00	ے ا	7019	ι /	000/
(0			Minipieted cause of deat	1011	NI Charl	u Ct T	S M 29M V	N2	120	Z
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Souli	4 90	v · · ·	, _	1	
	Regist	ar	JUL 2 0	ZUU/	De St.	LHOSARA					

State of Maryland / Department of Health and Mental Hygiene U

Certificate of Death

I	Physician	
	/Medical	
	Examiner	

Funeral

þ

Completed

Be

2

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

State

Registrar

CECILIA LENOR ALBORNOZ 4a. Facility Name (If not institution, give street and number)

4b. City. Town, or Location of Death

2. Date of Death 3. Time of Death ^{Day} 2007 JULY 4, 9:00p

National Institutes of Health 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 X F

1. Decedent's Name (First, Middle, Last)

Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

10f. Zip Code

1⊠Yes 2□No

Days

4c. County of Death Montgomery

Year) 1949

Funeral Director

ns 23a or 28a-f sh must be notified

Examiner

the Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show

of Health and Mental Hygis filem 27 is marked other

Department of Important: If it any Injury or o once.

Physician

The law requires that the death certificate be executed

Box 68760.

P.0.

Records,

Division or Vital or Attending Physician:

/Medical Examiner

attending physician and for use as the burial-train

been signed by the should be detached

After

Director:

death.

24 hours

within 24 hou To the Fune completely fi

Baltimore, Maryland 21215-0036

Usual Residence of Decedent 10a. State Director

10b. County Edo-Portuguesa 10e. Street and Number Ave Vencedores De Araure, Residencias Villa David #13 1 ☐ Never Married 2 Married

Acarigua

10c. City, Town or Location

57

None 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

Venezuela 14. Race - American Indian, Black, White, etc.

9. Birthplace (State or Foreign

10d. Inside City Limits

Hispanic

1 ☐ Yes 2K No

Ecuador

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

3 ☐ Widowed 4 ☐ Divorced

College (1-4or 5+)

2 X No

12. Was Decedent Ever in U.S. Armed Forces?

Venezuelan 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Homemaker

Specify:

10g. Citizen of What Country?

1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:

None

Hugo Benitez

Lucia Casanas

7-10-07

DISTRESS

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type. Print) Jose Guillermo Albornoz/Spouse 20a. Method of Disposition

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ave Vencedores De Araure, Residencias Villa David13
Acarigua, Edo-Portuguesa 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

La Corteza Cemetery

Edo-Portuguesa Marshall's Funeral Home, Inc.

Acarigua,

4217 9th St. N.W. Washington, D.C. 20011 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death 2 MONTHS

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

VENTILATOR ASSUCIATED Due to (or as a consequence of):

ATIEMIA

2 MONTH MOHTH SYMDROME

SANDISOME

MYELODYSPLASTIC

Due to (or as a consequence of): ARMSTIC EARLS

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2⊠No

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death

SEVERE

ADULT RESPIRATORY

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

9 Unknown

4☐Pregnant at time of death 9☐Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☑ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2

26. Place of Death (Check only one)

MD

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 X No

3 ☐ Suicide

4 Homicide

25. Was case referred to medical

27. Manner of Death 1 Natural 2 Accident

Hospital: 1 Npatient 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

BETHESDA,

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D63353 MD

29d. Date signed (Month, Day, Year) JULY 4TH

20892

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

AN REMCE 31. Date filed (Month, Day, Year)

JUL 0 6 2007

6 ☐ Could not be

determined

CENTER DRIVE, CIM 32. Registrar's Signature

			For State Registrar	State of Ma	aryland /		tificate of L			Reg. No.	J/	: 3333
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) James Ellswort		own, Sr	· •			2. Date of Dea Month July 8	Day	Year	3. Time of Death 11:00 A ^M
	Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, or	Location of Death		4c. County	ol Death	
			400 Glades Square					land			rret	
ı	Funeral Director		5. Social Security Number 6. Sex 214-22-2673	IM alle	80	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day May 21	r, Year)	Cour	place (State or Foreign ntry) Virginia
Marylend	farylend	ō	10a. State 10b. County		10c. City, To	wn or Lo					1	10d. Inside City Limits 1 🛣 es 2 ☐ No
	28a-	rect	MD Garret 10e. Street and Number	10f. Zip Code			10g. Citizen of V	What Cour	ntry?			
	h with	O E	400 Glades Square				2	1550		U	SA	
S after death	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hyglene. Item 27 is marked other then "naturel", or Items 23s or 28s-f ehow other traumatic event, the Madical Experiment and be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 ☐ N If Yes, Give Year or Dates: V	lo		Was Decedent of H i Yes, specify Cuba □ Yes 2 X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Rac Blac Specify	ck, White,	can Indian, etc. hite
200-	2 hou	ted	15. Decedent's Edu	cation		a. Deced	lent's Usual Occup	ation		16b. Kind of Bu	usiness/In	idustry
within 72 lene.	d within 7. glene. r then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	+)		kind of work done of DO NOT use retired elder	ation during most of work f)		Cooper :	Mill		
2	ai Hyg I othe	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle,	Maiden Suman	10)	
yiarid	Menta Menta arked	To	Thomas Salem	Brown				Mabel	Mayb	elle Up	hold	
Na	2 sho		19a. Informant's Name/Relationship (Ty				•	and Number or Rui		_		o Code)
e Ú	1 and Health sm 27 ther t		Kathryn Holland/ I	aughter				k Lane, E	Fairmont Date	, WV 2 20c. Location -	6556	own State
Daillinor	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other ance.		1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		_	a Cr	sition (Name of natory or other place cematory	7/10	0/07	Morgan	town,	, WV
Da	permit Depar impor any in		21. Signature of Funeral Service Licent	Tow		St		neral Hom	ne Oak	S. Seco land, M		1550
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused te cause on each lin	the death. Do	not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Atheros	sclerot	ic C	ardiovas	cular Dis	sease			Years
	/Medical Examiner		resulting in dealth)	Due to (or as a	a consequence	e ol):						
	The state of	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a	ă consequenci	e of).						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
Š,	icate be executed physicien and s the burial-transit	l Exa	resulting in death) Last	a consequence	sequence of):							
0/00,	cate b	edical		J							-	
O. BOX 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy				ite of deliver	re ry Day Year
ŗ	that the ned by detact	by Ph	Part II. Other significant conditions con	ntributing to death bu	ut not resulting	j in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use conf	tribute to t	the cause of death?
Spics	quires an sign								1 🗆 Y	es 2 No	3 ☐ Prof	bably 4 Unknown
COSE	The law re te hes bee age 2 sho	Completed								rmed?	Were autoprior to co death?	opsy findings available ompletion of cause of
	an: 1	a	25. Was case referred to medical					26. Place of Dea	th (Check only o	77	10163	2010
>	hysic his ce i direc	To B	examiner? 1 Yes 2 □ No	lospital: 1 ☐ Inpatie	nt 2 ER/C	Dutpatien	t_3□ DOA Oth	er: 4 🗆 Nursing H	ome 5 Resid	dence 6 🗆 Oth	ner (Speci	fy)
	auth. or: After the		27. Manner ol Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	ry 28b Year)	. Time of Injury	Wor	yat k? Yes 2 ☐ No	28d. Describe !	now inju <i>r</i> y occur	red	
	tai or Att s efter de si Dirscte ed in by ti	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury - At home, c. (Specify)	larm, str	eet, lactory, office		28l. Location (S City or Tox		er or Run	ral Route Number,
	n 24 hour n 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 ☐ Certifying Physical Exami	sician: To the best on the basis of and manner sta	examination a	ge, deat! and/or in	n occurred at the time vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and maded	anner as s and due t	stated. to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	1/11-			29c. Licens	e number		29d. Date signe		
	6110		/enly	100			He	64705		7/8	3/0-	/
7	F [V 17		30. Name and address of person who co Dr. Richard A. Por					, Oakland	l, Maryl	and 21.	550	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 12 2	32. Registra	ar's Signature		books					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 03 William Claire Brvan Ju1y 2007 17:16 M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Caroline Caroline Home for Hospice Denton 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours XXM 2 F 212-58-8450 Jan. 23, 1951 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 1X Yes 2 □ No Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Park Avenue 21639 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes Z☐XNo If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 12 Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phillip Bryan Jenny Singleton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Bryan/Ex-wife 101 Park Ave., Greensboro, MD 21639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Reg. July 3,2007 Hanover, Maryland 4 Conation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Michael 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG CANCER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Department of I-Important: If ite any Injury or ot

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

o e ns 23a must b

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23 array or other traumatic event, the Me "and Examiner musts array or other traumatic event, the Me "and Examiner musts".

Al Hygiene.
Ad other thar
c event, the

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

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MD

ohysician and the burial-trans use as t signed by the a s certificate ha funeral director.

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records.

or Attending Physician:

the

After this

s after death.

within 24 hours af

To the Funeral D

completely filled in Hospital

in by t

Examiner Physician/Medical Completed by Be မ Certification:

IF FEMALE 23b. Was decedent pregnant 9 Tinknown 25. Was case referred to medical

ARTHERIO SCUEROTIC CARDIOVASCULAR

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

24a. Was an performe 1□ Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No

27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work? 1 □ Yes 2 □ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

3 ☐ Suicide

4 ☐ Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

1 KCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier ans Jany

00057509

316 RAILROAD AVE. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES E. LACET, NO PO 120× 122 GOLDSBORD, MO ZIEZE

Registrar

Medical

31. Date filed (Month, Day, Year) JUL **5 2007** 32. pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 10, 2007 **Physician** 4:15 A Dona 1d Gordon Bowser /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 785 Brant Road Swanton Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 98 Yrs. 215-12-2116 1908 Maryland Sept. 14, Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County other than "netural", or iteme 23a or 28a-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 785 Brant Road 21561 USA death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othn eny injury or other treumatic event, 9008. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter J. Bowser Lenore Upho1d 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Wilburn/ Niece 808 Brant Road, Swanton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glendale Cemetery 7/12/07 Swanton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signal are of Funeral Service 32 S. Second St. Oakland, MD 21550 Stewart Funeral Home 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) acute **Physician** Ve hu week /Medical Due to (or as a consequence of): Examiner Chronic renu ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attemscle 1251 1ears Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 No Completed peed 24a. Was an autopsy performed?
1 ☐ Yes 2 ₺ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 🗖 No 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

walter

31. Date filed (Month, Day, Year)

JUL 12

2

0025759

BUX 247. Accident MD

July 10,2007

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Naymann

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 1, Year **Physician** 2007 BELL Frances Sarah 9:10 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 515 Apple Grove Rd Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 8, 1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours Min New York 109-05-0048 90 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28a-f show other treumatic event, the Medical Examples must be notified at 1 ☐ Yes 2 No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 515 Apple Grove Rd. USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ă Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Account ing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Shainman Molly Kramer ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Bell / son P.O. Box 3192, Jerusalem, Israel 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State artment of ortent: If i 1 → Burial 2 Cremation 3 Removal from State ŏ Mt. Lebanon Cemetery | July 3, 2007 Adelphi, MD ^¹ 4 □ Donation 5 □ Other (Specify) permit.
Departm Importer any inju 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Juneral Service Lice 254 CArroll St., N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications accused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 8 years Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine attending physician and for use as the buriat-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months?
1 □ Yes 2 ☒ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by icate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 ther (Spansisted livin 2 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour.
the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number WDean NW D47654 0 July 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlotte Dean. MD 110 Irving St., NW, Washington, DC 20010 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

05

2007

Pleas

If Under 1 Year

Months

Days

7. Age (In yrs. last birthday)

10c. City, Town or Location

Silver Spring

74

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.											
State of Maryland / Department of Health and Mental Hygiene											
For State Registrar		Certificate of Death	Reg	g. No,	2335						
1. Decedent's Name (F	First, Middle, Last)		Date of Death Month		3. Time of Death						
Robert	Burt	Berman	July 3,	2007	4:15 A ^N						
4a. Facility Name (If no 1725 Brigs	cility Name (If not institution, give street and number) 25 Briggs Road 4b. City, Town, or Location of Death Silver Spring 4c. County of Montg										

If Under 24 Hrs

Hours

Min.

8. Date of Birth (Month, Day, Year)

1933

10g. Citizen of What Country?

Specify:

Linen

United States

16b. Kind of Business/Industry

20c. Location - City or Town, State

Adelphi, MD

14. Race - American Indian

Black, White, etc.

May 6,

Birthplace (State or Foreign Country)

White

New York

10d. Inside City Limits

Approximate
Interval Between
Onset and Death
Six Months

1 X Yes 2 □ No

Physician /Medical Examiner

Funeral

Director

6. Sex

Montgomery

X□ M 2□ F

5. Social Security Number

Usual Residence of Decedent

10b. County

267**-**46-7087

MD

10a. State

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at d 2 should be filed w h and Mental Hygie 7 is marked other tl

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

The law requires that the death certificate be executed burial-trar and the attending physician the as for use detached s been signed by the should be detach cate has t certificate or Attending Physician: funeral director, this After s after death. the filled in by within 24 hours a To the Hospital

Division or Vital Records, P.O. Box 68760

Director 10e. Street and Number 10f. Zip Code 20906 1725 Briggs Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ ※ No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Billings Benjamin Berman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 Falls Chapel Way Rockville MD 20850 Steve Berman - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Lebanon Cemetery 7/3/07 22 Name and Address of Facility ward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Sacrice Locales 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Chronic Obstructive Lung Diseases Completed Diabetes Mellitis 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Medical Certification: To I 1 ☐ Yes 2 ▼No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 XNatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Hunknown 1 🗌 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【XNo 24a. Was an autopsy performed? 1∐ Yes 2 X No 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) July 3, 2007 MD 7158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth Goldstein MD 5530 Wisconsin Avenue Suite 1125 Chevy Chase MD 20815 egistrar's Signature 2007

State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Kennel

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death : 30PM Bredice 0 200 Danato 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bethesda Hill Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Months 12 M 2□F Yrs. 1912 Washington, D.C. 577-32-4491 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 3154 Gracefield Road #209 20904 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify þ Specify: 3 Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) District of Columbia Elementary/Secondary (0-12) College (1-4or 5+) Schools Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Unknown Gaetano Bredice 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Neam - Brother-in-law 3154 Gracefield Road #209, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 7/5/2007 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funera 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1 Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mass Lunknown etislog Due to (or as a consequence of): ainless Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Iver Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2**X** No 1 ☐ Yes 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes Mellitz Diabetes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) No. 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1 Inpatient

Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar for signed by the a certificate has I rector, page 2 s this After within 24 hours after death

To the Funeral Director;
completely filled in by the

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

death with

1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i

nd Mental Hygiene. marked other than

h and Mental F

of Health

Physician /Medical

Pages 1

other t Department of Healt Important: If item 2 any injury or other once,

> 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature/and itle of certifier

State Registrar

Medical

Tulip Hill Terr. Bethesda, 6844 nx strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mil

2007

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31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0440 **Physician** Gloria Latter 7/1/2007 Bronstein /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day 4/3/1931 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 1 □ M 💥 □ F Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland , and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1X Yes 2 No Funeral Director Md. Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6121 Montrose Rd. 20852 US 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Statistician Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any lighty or other traumatic evone. Rose Schneider Samue1 Latter ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14701 Botany Way N. Potomac, Md. 20878 David Latter/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 7/3/2007 Olney, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Understanding to the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed y physician and as the burial-tran Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☒ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 ☐ Unknown signed by t d be detach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by End stage renal disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an nas autopsy performed? certificate 2**X** No or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 2 ER/Outpatient 3 DOA ၉ 1 ☐ Yes 1X Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera Certification: Division (Month, Day Year) 1 🖾 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 0person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Atul Rohatgi 8600 Old Georgetown Rd. Bethesda, Md. 20814 31. Date filed (Month, Day, egistrar's Signature State JUL Registrar

DHMH 17 Rev 1/2001

11/101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Louise Gilbert Bulgher рМ /Medical 2007 July 1, 1:53 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3118 Gracefield Road, CC110 Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery

9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) 1 □ M 2 🖾 F Months Days Hours Yrs. Director 577-20-7644 85 July 7, 1921 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 3118 Gracefield Road, CC110 20904 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 0 1 ☐ Yes 2√€ No Specify: White ò 3 Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be inent of Health and Mental Intern 27 is marked or 2 Cary Durrette Gilbert Parthenia May Sims 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Bulgher/ Son 1722 Saddle Drive, Gambrills, MD 21054 : If Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department or
Important: If I
any Injury or
once. 1 TBurial 2 □ Cremation 3 □ Removal from State July Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2007 Rockville, Maryland 21. Signature of Juneral Service Licen 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Ullen 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Congestive Heart Failure 2 Weeks resulting in death) /Medical Due to (or as a consequence of): Examiner Mitral Valve Insufficiency Sequentially list conditions, if any, leading to minimum cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2-3 Months Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy or in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Anemia, Chronic Kidney Disease, Pulmonary Sarcoidosis 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has t irector, page 2 s autopsy death? 1 ☐ Yes 2 ☐ No performed' 24⊡ No director 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) ပို 1 ☐ Yes 🍇 🛣 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 Division or Vital Records, P.O. Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

D

Medical

31. Date filed (Month, Day, Year) State

JUL 0 6 2007

29b. Signature and title of ertifice

29a. Certifier

(Check only one)



29c. License number

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D23649 July 3, 2007

3110 Gracefield Road, Silver Spring, MD 20904

egistrar's Signature

Registrar

07-04833	
Margaret Barber	

07-04833 Margaret Barber		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene												
Planticia	F	- For State Registrar 1. Decedent's Name (First, Midd			•		f Death				Reg. No.	1.	, ,	3. Time of Death
Physiciar Medical Examin	or	Margaret Emma	·	arbar						Month June 25,	Day	Year		0540 hrs
JP*		4a. Facility Name (if not institution Suburban Hebrew Home of Cred	on, give street and HOSDITAL eter Wachingt	number) On			4b. City, Town, Bethe	or Location of			4c	County of		
Funeral	7	5. Social Security Number	6. Sex	7. Age	(In yrs. last bi	rthday)	If Under 1 Ye	ear If Unde	er 24Hrs. 8	. Date of B		DD/YYYY)	9. Birth	place (State or
Director	-	219-18-5139 Usual Residence of Decedent	1 M 2XX	:	83	Yr		ays Hours		Feb. 24, 1924 Country M				ntry) Maryland
any:		10a. State 10b. County	<u> </u>	1	0c. City, Tow	n or Loca	tion						- T	10d. Inside City Limits
death with the Maryland or items 23a or 28a-f show must be notified at once.	<u>.</u>	Maryland Montg	omery		Rockvi	11e	140(7: 0. 1		1		10 000			1 Yes 2 No
the Mar a or 28s	을 =	12104 Forestva	le Drive				10f. Zip Code 2085					en of Wha		•
th with	Funeral	11. Marital Status 1 Never Married 2 M		ecedent E Forces?	ver in U.S.		as Decedent of I es, specify Cub				lo-	14. Race - White,		an Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiest are 23 or 288-f she 27 is marked other than "natural", or items 23a or 288-f she 27 is marked other than "natural",	by Fur	7.0	1 Yes		No	1	Yes 2 X		cify: Specify: Whi					e
natura xamin	<u></u>		during m				ent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)					and of Busi	ness/In	dustry
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Opparament of Health and Mental Hygienic Important. If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) 12	College	(1-4 or 5+	·	mema		16. 20 1401	use rear qu		Owr	n Home	2	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than e event, the Medica	탕	17. Father's Name (First, Middle	e, Last)					18.Mother	r's Name (Fi	rst, Middle,	, Maiden	Surname)		
121 J be fill ental F arked vent,	8	Frederick Grov	er					Emma	F K	111				
MD 2 d 2 should th and M n 27 is m	- 1	19a. Informant's Name/Relations oAnne Hobelman		nter			g Address (Str							Zip Code)
and 2 lealth if tem 2 traum	- 1-	20a. Method of Disposition	ii Daugi	iter			sition (Name of			ate		ocation - C		own, State
More Pages 1 lent of H unt: If i		1 Burial 2 X Cremation		from State	- 1	-	herplace) 1n Crem	atory	7/12	/2007			-	, Maryland
Baltimore, permit Pages I ar Department of Hea Important: If ites injury or other tr	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute, 10												
	-	Simple Tribute, 1040 Pike, Rockville, MD, 23a. Parl/I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart A											20852	
Physician /Medical		23a. Partyl. Enter the disease, or failure. List only one cause	on each line.					g, such as c	cardiac or re	spiratory a	rrest, sho	ck, or héar	1	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. <u>Intrac</u>		al herror	rhage							\rightarrow	Death
	-	Sequentially list conditions,	b	o a concoq	301130 017.									
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h = =		(Disease or injury that initiated events resulting in death) Last	Due to (or as	s a conseq	uence of):					-			\neg	
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876 tificate ng phy as the	2	F FEMALE: 3b. Was decedent pregnant in the	ho .	s, outcome e birth	of pregnancy		etal death	Ectopi	c pregnancy	,	230	i. Date of do Month	elivery Da	av Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medi	past 12 months? 1 Yes 2 ✓ No 9 Unit	known	_	ne of death		ther (Specify)							
D. BC	ڇڄ ٻ	Part II. Other significant condit	9	(nown	ust not specific	an in the	radadi in a sara	a siyaa ia Da		220 Did	tohosoo	uso contrib	uto to th	ne cause of death?
i, P.O. B ires that the d signed by the I be detached	~	art II. Other significant condit	nona contributing	i to death t	out not resulti	ing in the	underlying causi	e given in Fa	dil I.					bly 4XX Unknown
cords, law require has been si	Completed					-				24a. Was	s an			opsy findings available
COF e law r e has b											ormed?	de	ath?	mpletion of cause of
Vital Rec ysician: The l		25. Was case referred to medica	n T				26 Pla	ce of Death	(Check only	1 Yes	2 N	1	✓ Yes	2 No
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n of ding Ph		27. Manner of Death 28a. Date of Injury 28b. Time of Inj						jury at Work	c? 28	d. Describe	how inju	ігу оссиггес	t	
ttendi death.	atio	1 X Natural 5 Pend 2 Accident Inves					1	Yes 2	No .					
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. Recent After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	וצ		Id not be rmined (Specif		ry - At home,	farm, stre	et, factory, office	building, et	tc. 28f	f. Location or Town,		nd Number	or Rura	al Route Number, City
hou hou	The state of the s							death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
Certifying Physician: To the best of my knowledge, death occurre (check only one) Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and all the officertifier							//or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Ye							
		and alignature and little officertife		IL	1			nse number C.M.E.				e 27, 200		n, ∪ay, Year)
	30. Name and address of person who completed cause of death (Item 23a)								10.0100	4				
	Susan Hogan MD. Assistant Medical Examiner 111 Per							uumore, I	MD 5150	F				

State 31. Date filed (Month, Day Year) 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2007 M 0 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wicomico Hospice at the Salisbur If Under 1 Year If Under 24 H Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth Age (In vrs. last birthday **Funeral** Days Sept. 25, ^Y221 1X M 2□ F 85 Months Hours 218-16-5905 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County items 23a or 28a-f show Examiner must be notified at MD Dordester 1 ☐ Yes 2X No Director Crapo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21626 3155 Robbins Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1942 If Yes, Give 1945 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify þ If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced "natural", white Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 11 machinist shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milford Franklin Creighton Cora Dean ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3155 Robbins Road, Crapo, MD 21626 Alma Creighton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/10/2007 Injury Robbins, MD 4 Donation 5 Dother (Specify) Sandy Island 22. Name and Address of Facility Thomas Funeral Home, P.A. 21. Signature of Funeral Service Licensee any 700 Locust Street, Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and Due to (or as a consequence of) burial Box 68760 physician Physician/Medical the as attending _I IF FEMALE use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy ó in the past 12 months? Month 5 Other (specify) P.O. the 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy performed page 2 No certificate 1 TYes Division or Vital 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Tyes 1 Inpatient P After this uneral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 1/5 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0058410

State Registrar 6 HULAM

31. Date filed (Month, Day, Year)

PO. BOX 1733 SAMS13UR

HOSPICE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARE

COASTAL

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 3:00 PM 200 Elva Nellie Crawford /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Yrs. Director 81 14, 1926 | Maryland 215-26-1640 Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No iral", or items 23a or 28a-f sl Examiner must be notified Directo Maryland Washington Hagerstown the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or items 23a or: 21742 U.S.A. 11911 Wesley Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: þ 3X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be trainent of Health and Ments tant: If item 27 is marked **Blickenstaff** Arie Michael Kline Emma ၉ 19a. Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2328 Warm Springs Road Shennadoah WV 25442</u> Fred Gary Crawford / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery | 7/12/2007 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign Vire of Funeral Service Licens Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due of or as a consequence of): Examiner and Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the at d be detached for 2 🗆 No or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 M No certificate 1∐ Yes Physician; 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Hospital or Attending (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 D5036

SH-3

State Registrar

Dr (antone
31. Date filed (Month, Day, Year)

JIII 1 1 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22911 Jesserson 132. Registrar's Signature
7 Secur S. Special

		•	For State Registrar	State of Ma	-	epartment of F Certificate of			giene	7 23370
	i.:		1. Decedent's Name (First, Middle, Las.)				2. Date of De	ath Day Yea	3. Time of Death
	hysici: /Medic	al	Kathreen Louise (17	9 07	13 38РМ
Fu	xamin	Ĭ	4a. Facility Name (If not institution, give Beverly Living Ce 5. Social Security Number 6. Se	enter x 7. Age	(In yrs. last birtho	Hage:		rs. 8. Date of Bir n. (Month, Oa	y, Year)	gton Birthplace (State or Foreign Country)
	ector		217-10-2832 Usual Residence of Decedent		01 **			Aug. 4	1915 M	aryland
yland	MOL III		10a. State 10b. County		10c. City, Town	r Location				10d. Inside City Limits
Mar	DE ST	cto	Maryland Washin	gton		Hagerstow	m			1. Yes 2 No
ith with th	23a or 28 ust be no	ral Director	10e. Street and Number 750 Dual Highway			10f. Zip Code 2174			10g. Citizen of What	
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	rai', or iteme Examinar m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 🗓 Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	ver in U.S.	13. Was Decedent of In If Yes, specify Cub 1 ☐ Yes 2 No		(Specify Yes or No erto Rican, etc.)	Black, W	mencan Indian, Thite, etc. Vhite
5-0	deal	Completed	15. Decedent's Ed (Specify only highest grad	ication le completed)	(0	ecedent's Usual Occup Give kind of work done	during most of w	rorking	16b. Kind of Busine	ss/Industry
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Hygie	nt.	ပ္ပ	17. Father's Name (First, Middle, Last)	U		nurses aru	,	ame (First, Middle	Maiden Sumame)	nome
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Baltimore, Maryland permit. Peges 1 and 2 should be file Department of Health and Mental Hy	n nati	္	19a. Informant's Name/Relationship (7	ype, Print)	19b. N	failing Address (Street	and Number or	Rural Route Numb	er, City or Town, State	e, Zip Code)
Martin S	27 ie r trau		Connie Oestereich	- daughte	r 76	10 Overloo	k Drive	, Boonsbo	ro, Md. 2	1713
S 1 a	item othe		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pla	ce)	Date	20c. Location - City	or Town, State
Pege Pege	ant: if		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		i	own Cremat	·	10/07	Hagerstov	m, Maryland
alt spartr	mport		21. Signature - Funeral Service Licen	hm	-^ O	22. Name and Addre			n Funeral	
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/Me Exar	ohysician and the burial-transit the burial-transit	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Chyon Due to (or as a Due to (or as a	consequence of	structin	e aci	way o	disase	Interval Between Onset and Death
.O. Box 6	by the attending pached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of Month	delivery Day Year
rds, F quires the	should be det	ed by F	Part II. Other significant conditions co	ntributing to death but	not resulting in t	ne underlying cause gr	ven in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records, i or Attending Physician: The law requires effer death.	5 CI	Completed						24a. Was auto perfo 1 ☐ Yes	osy prior death	autopsy findings available to completion of cause of 1? es 2 No
Vit	certif	Be	25. Was case referred to medical examiner?	Hospital:		Ott		eath (Check only o		
P O	r this	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day			ry at		dence 6 Other (S	ipecity)
Division of Vital or Attending Physician:	irector: Afte tby the fune	Certification:	Natural 5 Pending investigation 3 Suicide 6 Could not be determined		y - At home, farm		rk?]Yes 2 □ N <i>o</i>		Street and Number of	Rural Route Number,
To the Hospital o	To the Funeral Director: After this certificate ha completely filled in by the funeral director, pege	Medical Cer	29a. Certifier Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of and manner state	examination and/	death occurred at the ti or investigation, in my	ime, date and pla opinion, death oc	ice, and due to the	cause(s) and manner date and place, and	r as stated. due to the cause(s)
To the within 2	To th	Me	29b. Signature and title of certifier	g Au	al		se number	35	29d. Date signed (M. 7/9/6)	* -
WH-	3		30. Name and address of person who of	ompleted cause of de	ath (kem 23a) (T	ype, Print) 7 MWW	Stra	r Houg	notonn	MD 21740
F	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 0 2	32. Registrar	's Signature	1				
DHMH 17	Rev 1/2	001		Hire	OF	RIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day PHILLIP CURVAN 2007 5:30 P M JUNE 26 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death MANOR CARE NURSING HOME T.ARGC PRINCE GEORGE'S 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day) Months Days Hours 123 M 2□ F 217-04-1132 79 APRIL 18 TRINADAD 1928 Usual Residence of Decedent 10a State 10c City Town or Location 10b. County 10d. Inside City Limits 1. Yes 2 No PRINCE GEORGE'S MD LARGO 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 811 NARROWLEAF DRIVE 20774 TRINADAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No BLACK Specify: 3 ⊠ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th ACCOUNTANT GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ASHTON CURVAN CLAUDINE FARMER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNE W. MASSIAH/DAUGHTER 811 NARROWLEAF DRIVE LARGO, MARYLAND 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 7/2/2007 RIVERDALE, MARYLAND 4 □ Donation 5 □ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service 22. Name and Address of Facility cicensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an 2**⊠** No 1□ Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Examiner must be notified at

Director

by Funeral

Completed

Be

2

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event

Baltimore, Maryland 21215-0036

as filled in by

lospital or Attending Physician: The law requires that the death certificate be executed and attending physician the nas After 4 hours after death Funeral Director;

Division or Vital Records, P.O. Box 68760,

To the within 2 To the complet	Med
CR (3)	
Sta Registr	

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 25. Was case referred to medical examiner? Be Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated.

29c. License number

KAR KWAY

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) 0 6 2007

ICTOR

29b. Signature and title of certifier

32. Registrar's Signature

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			State of Maryland / Dep		Mental Hygiene)	
	b		1 - State Registrar Amend #5, perFH, G869, 7/31/07 TT Ce	rtificate of Death	Reg. No.		2 7 7 7
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	Year	3. Time of Death
	/Medic		Mavis Veronica Clarke	4h City Town and continued Doubt	June 25	County of Deat	11:48 am
)	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			
A Second		9	Holy Cross Hospital 5. Social Security (Number 6. Sex. 7. Age (In yrs. last birthday)	Silver Spring If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgom 9. Birtl	hplace (State or Foreign
	Funeral Director		0786 577-98- 0784 1□M 2⊠F 60 Yrs.	Months Days Hours Min.	Jan. 30, 19	Co	uintry) maica
			Usual Residence of Decedent		pair. 30, 12	17 04	
	yland how at		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-f sl	당	Maryland Montgomery Rockvill	.e			1⊠Yes 2 No
	or 28	Directo	10e. Street and Number	10f. Zip Code	10g. Cit	izen of What Co	untry?
	23a ust b		13608 Grenoble Drive	20853		ited St	
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show sdical Examiner must be notified at	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	 Race - Amer Black, White 	
20	s afte	by F	1 ☐ Never Married 2 ⊠ Married 1 ☐ Yes 2 ဩ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: p.1	ack
5-0036	hour tural	었		dent's Usual Occupation	16b. K	ind of Business/	
င်	in 72	Completed	(Specify only highest grade completed) (Give	kind of work done during most of word DO NOT use retired)			,
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Ö	filed Hyg other ent, 1	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden	Surname)	
<u>a</u>	lid be lental ked (To B	Gilbert Poyser	Ida S	Stewart		
Maryland	and 2 should be filed within 72 hou alth and Mental Hygiene. 127 is marked other than "natural er traumatic event, the Medical E.	-	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Ru	ıral Route Number, City o	or Town, State, Z	Zip Code)
	1 and 2 Health a em 27 is		Rupert William Clarke/ Spouse 13608	Grenoble Drive,	Rockville,	Marylan	d 20853
ā,	- P = E		20a. Method of Disposition 20b. Place of Disposition cometery, cre	osition (Name of matory or other place)	Date 20c. Lo	ocation - City or	Town, State
Ë	Pages nent of h ant: If ite		1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of	Heaven Cemetery 7	/7/07 Si	lver Spi	ring, MD
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Si	mple Tribut	e	
ñ	o a L	5 10	10 X (10	40 Rockville Pike	Rockville		and 20852
r.	1 8 5 1		23a. Part. Enter the disease or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
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	/Medical		resulting in death) Due to (or as a consequence of):				
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	p . <u>#</u>	Examiner	cause. Enter Underlying				
	ecute and trans	am	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				4 months
Ď,	cate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
09/8	icate l physi s the b	dical	d				
ž O	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of del	iven
ROX	eath atten for u	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month	Day Year
-	at the de by the a tached	iysi	1 □ Yes 2 No 9 □ Unknown				
J	that led by deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
G S	juires n sign lid be	d by	Superior vena cava syndrome		1 ☐ Yes 2	!□ No 3□ Pi	robably 4 Unknown
Vital Records, P.O	w requires that been signed t should be deta	Completed			24a. Was an	24b. Were au	utopsy findings available
2	he la e has age 2	щ			autopsy performed?	death?	completion of cause of
<u> </u>	ifficat or, pa		25. Was case referred to medical	26. Place of Dea	1 Yes 2 No ath (Check only one)	o 1 ☐ Yes	2/2/100
	h ysician: The law his certificate has b I director, page 2 s	To Be	examiner? 1 Yes 2 No Hospital: 11 Inpatient 2 ER/Outpatie	_ Other:	Home 5 ☐ Residence	6 ∏Other (Spe	ecify)
Ö	g Phy er thi	i.	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how inju		
Ö	ath. r: At	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division or	Atte er deg recto by th	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street a. City or Town, Stat		ural Route Number,
5	Ital or rs ar ral Di	Certification:					
	Jo the Hospital or Attending Physician: within 24 hours at a death. To the Funeral Director: After this certifica completely filled in by the fureral director, I	Medical	29a. Certifier (Check only (
	Jo the within 2.	Jed	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d Da	ate signed (Moni	th Day Year)
\					_		
•	6		Barbara Suparich By M 30. Name and address of person who completed cause of leath (Item 23) (Type	D D0065485		6/26	12007
				Glen Road, Silver	Spring. MD	20910	
	Sta	ite			- <u>r</u> ,		
	Regist		JUL 0 5 2007	parti			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 4:20 ам July 2007 Jack Wesley Courtner 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3534 Twin Branches Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 X M 2 □ F 90 492-18-1747 Oklahoma February 12, 1917 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Silver Spring Montgomery 10e. Street end Number 10f. Zip Code 10q. Citizen of What Country? 3534 Twin Branches Drive 20906 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Ordnance Program Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Collins Holloway John Wesley Courtner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3534 Twin Branches Drive, Silver Spring, Maryland 20906 Elisabeth V. Courtner - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) George Washington Cemetery 7/6/2007 Adelphi, Maryland 22. Name and Address of Facility 21. Signature Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. 23a, Part1 Immediate Cause (Final disease or condition resulting in death) (COPD) Emphysema Due to (or as a consequence of) Asthma, Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 \(\Delta\) Residence 6 \(\Delta\)Other (Specify) 2⊠ No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Box 68760. P.O. Division or Vital Records,

The law requires that the death certificate be executed burial-transi and attending physician as the nse for ate has been signed by the page 2 should be detached certificate Attending Physician: e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certific letely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic event, the Medical Examiner must be Is any Injury or other traumatic events.

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Maryland 21215-0036

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Certification:

Medical

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

State Registrar

31. Date filed (Month, Day, Year) JUL 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



the within 2 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0057304

29d. Date signed (Month, Day, Year)

July 2, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2007 June 24, **Physician** 1:20 а м Marie Claire Crittenden /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F Months 197-07-1906 Director 88 Aug 8, 1918 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐Yes 2 X No notified Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or Items 23a or adical Examiner must be r 20902 USA 901 Arcola Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 □ Divorced Completed l other than "natur vent, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Ith and Mental Hygie

7 Is marked other traumatic event, th Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Kelly John Vincent Maher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is r Bernadette Sweeney /Attorney Department of Health Important: If item 27 any Injury or other tronce. 77 S. Washington St., Suite 304, Rockville, MD 20850
Place of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Jun 29, 2007 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signature of Figneral Service Licenses 500 University Blvd. W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one complicate shocks are the complex of the c ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hyroxia /Medical Due to (or as a consequence of): Examiner Severe Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician an s the burial-tr Due to (or as a consequence of): P.O. Box 68760 Physician/Medical ast attending p IF FEMALE: 23c. if yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy perform 2**X** No 1□ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide XXI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours a To the Hosp within 24 ho To the Fund completely f

Maria Tayag, M.D., 1936 Kennedy Dr, #T-3, McLean, 31. Date filed (Month, Day, Year)

JUL 0 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

29b. Signature and title of certification

29c. License number

D63579

29d. Date signed (Month, Day, Year) July 3, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 28a per doc 9869 7-20-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2:20 PM DOT 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel South River Health & Rehab. Center Edgewater 9. Birthplace (State or Foreign Country)

9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 73 Yrs. 5. Social Security Number **Funeral** Months Days 7-44-0296 1**X** M 2□ F Director Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other than many injury or other traumaft event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 ARKWAY U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1953-1956 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify. Specify: ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Route Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Anna Meininger Weldon Bibb Drake, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94 Owenville Road, West River, Maryland 20778 James A. Drake - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 7/3/2007 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book an least failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 TYes 2 No 3 Probably 4 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes ✓ No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 2

State Registrar

31. Date filed (Month, Day, Year)

05

8516 TIMBERVAILEY Ct. Ellicott City, MD

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

1 - State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No.

2337

	_		Registrar			001	inical	COIL	Calli			Reg. N	0.		CIM CO	
	Physici	an	Decedent's Name (First, Middle, L.	.ast)							2. Date of D Month July		ay o o ¬	Year		of Death
	/Medic	-	Catherine Dreka								July				8:0	00 A M
,	Examin	er	4a. Facility Name (If not institution, g)			Town, or		of Death			c. County [ontg		7	
			968 Windbrooke D		ge (In yrs. las	et hirthday)		hersb	_	24 Hrs	8. Date of B		OILLE			e or Foreign
k	Funeral		5. Social Security Number 6. 263–38–2764	Sex 7. A	ge (<i>in yrs. i</i> as 7 8		Months		Hours	Min.	Oct 8	ay, Year	38	Flor	ntry)	or roreign
24	Director		Usual Residence of Decedent		70						000	, 17	20	1101		
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits			
	Mary -f sh	ρ	MD Montgom	erv	Gaith	ersbu	ırg								1 □ Y€	es 2 XNo
	r 28a notii	Director	10e. Street and Number					p Code				10g. C	Citizen of V	Vhat Cour	ntry?	
	3a ol	<u> </u>	968 Windbrooke D	rive			208	79				USA				
	deatl ms 2	Funeral	11. Marital Status	12. Was Deceden	Ever in U.S.	. 13.	Was Dece	dent of His	spanic O	rigin? (Spe	cify Yes or N Rican, etc.)	0-			an Indian,	
9	after or ite nine		1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 X If Yes, Give	No			2⊠ No			ritoari, etc.)			k, White,		
8	ral", c	by	3 ☐ Widowed 4X Divorced	Year or Dates:			1 1 1 65	221110	opeany				Specify	Whj	Lte	
2	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed by	15. Decedent's (Specify only highest g	Education grade completed)		16a. Dece (Give	dent's Usu	ial Occupa ork done d ise retired)	ation <i>uring mo</i>	st of worki	ng	16b.	Kind of Bu	isiness/In	dustry	
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2	ed w ygier ner th	Ö		5+		Fore	isic	Scien		anda Manana	/Fires 6.61-6-41				/ermi	3110
밀	be d c	Be	17. Father's Name (First, Middle, Last George Raymond D	*							(First, Middl Gaine		en Surnan	ie)		
$\frac{8}{5}$	should be filed within 72 hours after death with the Marylan and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	욘				405 14-75		- (04:1			al Route Num		T	04-4- 7:-	. 0	
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Baltimore,	permit. Page Department: Important: It any injury o		4 ☐ Donation 5 ☐ Other (Special Signature Funeral Setvice Aic		Jones											
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	Physician /Medical		disease or condition resulting in death)	a. Ovariar	Carci									-	2 y	ears
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ŏ	h cer andin use	N/S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		cy	⊒Ectopic p	orognanov.					23d. Da	te of deliv	ery	
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Ě	The ate his	Completed									per 1∐ Yes	form <u>ed?</u>	?	death? 1 🗌 Yes	2 ☐ No	
Vital	ian: ertifica	Be C	25. Was case referred to medical examiner?					112	26. Plac	e of Death	(Check only					
<u>_</u>	nysic nis ce	To E	1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ☐ E			OA Othe	er: 4□ N	lursing Ho	me 5X1 Re	sidence	6 □Oth	er (Speci	fy)	
0	Attending Physician: The law requires that the deardeath. cetor: After this certificate has been signed by the att by the funeral director, page 2 should be detached to		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D		28b. Time o Injury	of	28c. Injury Work	/ at c?		28d. Describe	e how in	jury occur	red		
30	errdll sath. or: A	atic	2 ☐ Accident investigat	he			М		Yes 2[
Division or	or Att ter de irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad Zoe. Flace of it	njury - At hom etc. <i>(Specify)</i>		reet, facto	ry, office			28f. Location City or T	(Street own, Sta	and Numb ate)	er or Run	al Route N	umber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Pirector: After this certificate has completely filled in by the funeral director, page 2.		V			1		M					/-> ·			
	Hosp 4 hou Fune tely fii	ical	(Check only 2 Medical Ex	Physician: To the best caminer: On the basis	of examination											e(s)
	thin 2 the mplet	Medical	one) 29b. Signature and title of certifier	and manner	stated.		29	9c. License	number			29d L	Date signe	d (Month	Day, Year	7)
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 9 2007

(10)02

Kevin Shannon, M.D. 6420 Rockledge Drive Suite 4100 Bethesda, MD 20817

			Pleas	e Type or Prin			delible Ink. artment of H		-		•		
			1 - State Registrar				tificate of L			Reg. No		7 2337	
	Physici /Medic		1. Decedent's Name (First, Middle, Howell Marion	,					2. Date of D Month July	2, 20	007	8:00 A M	
1	Examir	er	4a. Facility Name (If not institution,	-			4b. City, Town, or	Location of Death		4c. County of Death			
			7603 Shadywood		- /la .un lant hi	with along 1	Bethesda If Under 1 Year	If Under 24 Hrs.	Deto of B	- 1	lontgome	ery irthplace <i>(State or Foreigr</i>	
1 T	Funeral Director		579-52-9024	3. Sex 7. Ag	e (In yrs. last bii 92	Yrs.	Months Days	Hours Min.	8. Date of B (Month, E 09/18/)ay, Year, 1914	Year) Georgia		
	aryland show d at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits 1 🕱 Yes 2 □ No	
	r 28a-f	irecto	Maryland Montgom 10e. Street and Number	ery	Bethes	da	10f. Zip Code			10g. Ci	tizen of What (
	h with	a D	7603 Shadywood R	.oad			20817			Unit	ed Stat	tes	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 🖾 Divorced	12. Was Decedent Armed Forces?	No 1936-	. 1	Was Decedent of Hi f Yes, specity Cuba I ☐ Yes 2 123 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	lo-	14. Race - Am Black, Wh Specify: Wh	ite, etc.	
21215-0036	'natur	Be Completed	15. Decedent's (Specify only highest	s Education grade completed)	16a	. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation Juring most of work	ing	16b. k	Kind of Busines	s/Industry	
2121	d within giene. r than the Me	dwo	Elementary/Secondary (0-12)	College (1-4or 5	Mi Mi		ary Offic			U.S	S. Air	Force	
Maryland 2	uld be filed lental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, L Howell Marion E	,	·			18. Mother's Nam Juanita			n Surname)		
Mary	id 2 shouth and Mith		19a. Informant's Name/Relationshi				g Address (Street a			-		·	
Baltimore,	ages 1 ar ent of Hea nt: If item 2 y or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from State	20b. Place o cemete	of Dispo	sition (Name of natory or other place	e)	Date	20c. L	ocation - City o	or Town, State	
altii	permit. F Departm Importar any injur		21. Signature of Funeral Service L		ALLINE	22	. Name and Addres	s of Facility ${\sf Jos}$	eph Ga	wler	s Sons	Inc.	
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	ngton,	DC 20016 Approximate								
),	Physician /Medical Examiner		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_a Cardio	myopath a consequence	У						Interval Between Onset and Death	
	÷-,	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	a consequence	of):							
68760,	ate be executed hysician and the burial-transit	lical Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence	of):							
P.O. Box 6	The law requires that the death certificate the has been signed by the attending physionage 2 should be detached for use as the	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ∐Live birth 4 ∐Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date of d Month	elivery Day Year	
	uires that signed b	by P	Part II. Other significant condition Presumptive Co		_			en in Part I.				to the cause of death? Probably 4 🖾 Unknown	
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Vital F	in: The ificate or, pag		25. Was case referred to medical					26. Place of Dea	1□ Yes		o death′ 1 ☐ Ye	es 2[XNo	
Z	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatio	ent 2 ER/O	utpatien	t 3 DOA Othe				6 □Other (St	pecify)	
Division or	nding Ph th. r: After th e funeral	tion: 1	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b.	Time of Injury	Work	/ at (? Yes 2 □ No	28d. Describe	e how inju	ury occurred		
Divis	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flace of III	ury - At home, fa c. (Specify)	arm, str	eet, factory, office		28f. Location City or T	(Street a own, Stat	nd Number or le)	Rural Route Number,	
	ne Hospita 124 hours ne Funera eletely fille	Medical C		Physician: To the best examiner: On the basis of and manner st	f examination a								
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License		2270/2	29d. Da	ate signed (Mo	nth, Day, Year)	
	30		2 Tuch	Wholan	- WE	>		nia 01012	23/042	July	3, 200)7	
			30. Name and address of person v Erich Wedam MD 8		,			D 20889					
	Sta Regist		31. Date filed (Month, Day, Year)	2007 32. egišti	ar's Signature	4	ante						
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M		artment of Health and rtificate of Death	, ,	1	0.5050
	WI I		Decedent's Name (First, Middle,	Last)		Timodio or Dodin	2. Date of Deat	eg. No.	3. Time of Death
	Physic		Woodrow Corbett	Fleming			Month June 30	Day Year 2007	8:15 p M
	/Medi Examii		4a. Facility Name (If not institution,		")	4b. City, Town, or Location of Dea		4c. County of Death	10.10
			13108 Grenoble	Drive		Rockwille		Montgom	0.7517
	Funeral			6. Sex 7. A	ge (In yrs. last birthday)	Rockville If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birth	ery place (State or Foreign ntry)
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
	Aarylan f show ed at	ō							1 ☐ Yes 2 ☐ No
	the 28a-	rect	Maryland 10e. Street and Number	Montgomery	r Re	OCKVILLE 10f. Zip Code	1/	0g. Citizen of What Cou	
	with sa or	Ö	13108 Grenobl	A Duissa		20853			ndy:
	ms 2:	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	USA 14. Race - Americ	can Indian,
(C)	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at		1 ☐ Never Married 2 ☑ Marrie	Armed Forces ed 1 ∑ Yes 2 □	No	_	rto Rican, etc.)	Black, White,	
21215-0036	al', o Exan	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	1943-45	1 ☐ Yes 2 ☑ No Specify:		SpecifWhite	9
2-0	be filed within 72 ho ntal Hygiene. of other than "natur event, the Medical.	Completed	15. Decedent' (Specify only highest	s Education		dent's Usual Occupation kind of work done during most of we	orking	16b. Kind of Business/In	dustry
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<u>}</u>	should be and Mental s marked o	မ	George Flemin	J		Sally St			
Maryland			19a. Informant's Name/Relationsh Flora Josephin		19b. Maili	ng Address (Street and Number or F			
	1 an Heal		20a. Method of Disposition	- I Temilig, W		13108 Grenoble		20c. Location - City or To	
Baltimore,	0 0		1x Burial 2 ☐ Cremation		7	sition (Name of matory or other place)	ulv 5.	zoc. Eduation - City or 10	own, State
틀	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Sp 21. Signature Tuneral Service L			Memorial Park	2007 R	ockville, N	Maryland
Ba	permit. Departm Importa any inju					Name and Address of Facility in			
	-		23a. Part1. Enter the disease, or o	complications that cause		of 00 University B1 or the mode of dying, such as cardia			Approximate
	Thyololon		Immediate Cause (Final				, , , , , , , , , , , , , , , , , , , ,	4	Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)	- Ci.	age Renal D	isease			
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Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delive	ery Day Year
o.	he de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊔Pregnant a 9□Unknown	at time of death 5	Other (specify)		World,	Day Tour
<u> </u>	→ O 0		Part II. Other significant condition	' s contributing to death	out not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to the	he cause of death?
g, Q	w requires that s been signed b should be deta	Completed by	Pneumonia, Atri			, ,		s ——⊋⊡ No 3⊡ Prob	
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Records,	has Je 2	ld ll					24a. Was an autopsy perform	prior to co	psy findings available mpletion of cause of
_			25. Was easy referred to medical				1□ Yes 2	No 1 □ Yes	2□ No
5	Physiclan: this certific	Be c	25. Was case referred to medical examiner? 1 ☐ Yes ♣ No	Hospital:	ent 2 ☐ ER/Outpatien	Other	ath (Check only one		
	Phy er this eral d	1: To	27. Manner of Death	28a. Date of Inj	ury 28b. Time of	4 Nursing	Home 5 13 Resider 28d. Describe how	nce 6 Other (Specification of the control of the co	ý)
<u></u>	th.	tio	1X Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	ay Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
Division	Attending or death. rector: After by the funer	ifica	3 Suicide 6 Could no 4 Homicide determin	28e. Place of in	jury - At home, farm, str	eet, factory, office		eet and Number or Rura	Il Route Number,
=	s afte al Dir ed in	Certification:	. Плотногов	bullding, e	tc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral or		29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the basis of	of examination and/or in	n occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the ca curred at the time, da	use(s) and manner as s ite and place, and due to	tated. the cause(s)
	To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner s	tated.	29c. License number			
	2 1 8 1 8	-	In the state of th	Kolin.			59	d. Date signed (Month,	Day, redij
11	14		20 Name and address of the	ho completed	double (Hom COs) (T	D20367		July 2, 20	07
ſ,			30. Name and address of person w	Kalman, M.I		iccard Drive, Roc	rkwille N	ID 20850	
	Sta	te	31. Date filed (Month, Day, Year)	32. egist	rar's Signature	DIIVE, NOC	NATITE, I	10 20000	
	Registr		mn 0 5	2007	w & do	aut 1			

State Registrar 31. Date filed (Month, Day, Year) 32 egit 111 0 5 2007

Stephen Hellman, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brew & Signature

6240 Montrose Road, Rockville, MD 20852

Certificate of Death

Reg. No.

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Yea Physician Deanna Lynn Gagnon 10:00 A July2007 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F 44 276-70-3458 June 4, Director 1963 PA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r 28a-f show notified at 1 ☐ Yes 2X No MD Directo Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or 7 20503 Bargene Way 20874 United States Funeral ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hr Department of Healit and Mental Hyglene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Defense Contractor Program Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth H. Lecker Mary E. Sterrett ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. Gagnon / Husband 20503 Bargene Way, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Ju₁v 1 Burial 2 □ Cremation 3 Removal from State Neelsville Presbyterian 2007 4 ☐ Donation 5 ☐ Other (Specify) Germantown , MD 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Licensee Deer Park Drive, Gaithersburg, MD 20877 IRACIA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 1 Week /Medical Due to (or as a consequence of): **Examiner** Systemic Lupus Erythematosis 20 Years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of cate has l autopsy performed? death? 1 ☐ Yes 2 📉 No 1X Yes To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 📉 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43083 July 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George A. Sotos M.D., 9707 Medical Center Drive, #300, Rockville, MD 20850

State

Registrar

31. Date filed (Month, Day, Year)

JUL U 6 2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician ам July 4, Thomas Joseph Gownley, Jr. 2007 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □xM 2 □ F Yrs. Director 192-40-1055 55 Aug. 29, 1951 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 □Yes 2 □No Directo Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11332 King George Drive 20902 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ⊋Yes 2 No If Yes, Give Year or Dates 1970-73 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☐ No Specify. ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Government Parking Specialist marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Joseph Gownley, Sr. Anne Powers ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11332 King George Drive, Silver Spring, MD 20902 Karen McKeown Gownley/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 5, 4 ☐ Donation 5 ☐ Other (Specify) 2007 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Parti. Eiler the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Small-Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2√□ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 ☐ Yes 🔀 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To Hospice this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 29a, Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only

To the within 2.

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JUL 0 6 2007

Genevieve Wroblewski, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



m

and manner stated.

29c. License number

6001 Muncaster Mill Road, Rockville, MD 20855

29d. Date signed (Month, Day, Year)

July 5, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTFM/16a b perFH G869 7/23/07 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 5 200 5:01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SE 102 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 30 Director 217-08-7433 Dec. Maryland 16,1976 Usual Residence of Decedent with the Maryland a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a iner must b 119 W. Antietam St. by Funeral 21740 USA Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1¥ Never Married 2 Married 1□ Yes WNo Baltimore, Maryland 21215-0036 "natural", or Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed er than "natur , the Medical B 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Maponee. College (1-4or 5+) Unemployed Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gregory Radcliffe Hightman ၉ Loretta Wade Joyce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) <u> Gregory Hightman - Father</u> 1644 West Schwartz Blvd. The Villages, Florida 32159 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory July 9,2007 Smithsburg, Maryland 21. Signature of Funeral Servi OSBOT ME AFTENEFS ITY Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No is certificate has director, page 2 perform 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Hnpatient 2 ER/Outpatient 3 DOA this After thi funeral of 27. Mann Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 5 ☐ Pending investigation s after death.

I Director: A

Id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral DI

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0030355 30. Name and address of person who death (Item 23a) (Type, Prin 1-64C 0 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29c per dvr 8869 7-20-07 vt.
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	$C\epsilon$	ertificate of			J. No.	1
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Nicole Marie Hughes				July	7 200	7 9:50 PM
	Examir	ier	4a. Facility Name (If not institution, give street and nu	•		r Location of Death	·	4c. County of Dea	
	<u> </u>	1947. 1942.	Washington County Hos 5. Social Security Number 6. Sex	Oita⊥ 7. Age (In yrs. last birthday		agerstown If Under 24 Hrs.	8. Date of Birth	Washin	gton County rthplace (State or Foreign
-97	uneral Director		220-25-2541 Usual Residence of Decedent	17 Yrs.	Months Days	Hours Min.	Month, Day, 1 Nov 6	rear) (ountry) aryland
/land	at		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
Man	a-f sh tifiled	ctor	Maryland Washington	В	oonsboro				1 □Yes X□No
ith the	or 28 se noi	Director	10e. Street and Number		10f. Zip Code		100	j. Citizen of What C	ountry?
eath w	s 23a nust		306 Maple Avenue	adant Evenin II O		21713	- ''- \	U.S.	
aryland 21215-0036 should be filed within 72 hours after death with the Maryland	nd weather righter than "natural"; or frems 23a or 28a-f show marked other than "natural"; or frems 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Marital Status 1 Married 2 Married 3 Widowed 4 Divorced 12. Was Dec Armed F 1	2 🔀 No ve	. Was Decedent of P If Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
2 Por	natura ical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup	oation	16	bb. Kind of Business	s/Industry
Maryland 21215-0036 nd 2 should be filed within 72 hours af	grene. er than "r the Mcd	Be Completed		1-4or 5+)	e king of work gone DO NOT use retired student	during most of work d)	ing		
nd Ee file	d othe	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Ma	•	
Yan Neuld I	narke natic	ပို	unknown			-	M. Reed F		
Mal d 2 st	7 is n traun		19a. Informant's Name/Relationship (Type. Print) Dawn M. Russell - moth		-	and Number or Run	·		,
E dan	item 2		20a. Method of Disposition	20b. Place of Disp		enue Boons		YLANC 21 / 0c. Location - City o	
altimore, mit. Pages 1 ar	it if		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State 1	urg Cremat		0-2007	Smithsbur	g Maryland
Salti emit.	Department of nearing and wents Important: If item 27 is marked any injury or other traumatic ev		21. Signature of Funeral Service Licensee	. 2	22. Name and Addre	ess of Facility Doi	ıglas A.	Fiery Fur	eral Home
n 82	고드등리		Kaitin Jafaros						yland 21742
	*		23a. Part1. Enter the disease of complications that shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	iter the mode of dyii	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Sician ledical		disease or condition a. >	(or as a consequence of):					
Exa	aminer		61	LIOBLASTOMA	a muc	TIFORME	Ė		
D D	=	iner	Sequentially list conditions, if my leaf to cause. Enter Underlying Cause (Disease or injury	or as a consequence of):					
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60,	physician and is the burial-transit		, Bac to	(or as a consequence of).					
r 68760, rtificate be executed	ng phys as the	Medical	d					-1	
. BO	attendi for use	Physician/M	in the past 12 months?	nant at time of death 5	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of de Month	elivery D <i>a</i> y Year
P.O	d by the a	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to contributing the contributing to contributing the contributing to contributing the contributing to contributing the contributing to contributing the contributing		underlying cause aiv	en in Part I	23a Did taha	ana una contributa t	o the cause of death?
Vital Records, sician: The law requires t	been signed t should be detr	d by	INTRACRANIAL BLEE	_	andenying cause giv	eli ili Fait I.			robably 4 Unknown
CO N red	been	letec					24a. Was an		utopsy findings available
Pe g	has e 2	Completed					autopsy performe	prior to death?	completion of cause of
	certificate rector, pag	Be Co	25. Was case referred to medical			26. Place of Deatl	1 Yes 2 (Check only one)	diNo 1 □ Ye	s 2 ⋅ No
	this ceral direc	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑	Inpatient 2 ER/Outpatie	ent 3 DOA Oth	OF:		ce 6 □Other (Sp.	ecify)
JIVISION OF VITA or Attending Physician; iffer death.	After thunderal		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Mor	of Injury 28b. Time of Injury	Wor		28d. Describe how	injury occurred	
ISIO Itend	the f	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place	of injury - At home, farm, st		Yes 2 □ No	Of Longtion (Ctra	at and Mumber of F	Devide Aliverta
DIVISION OF tal or Attending Physics after death.	al Direct	Certification:	4 Homicide determined build	ing, etc. (Specify)			City or Town,	er and Number or F State)	tural Route Number,
the Hospital	To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1	e best of my knowledge, dea lasis of examination and/or in oner stated.	th occurred at the ti nvestigation, in my o	me, date and place, opinion, death occur	and due to the cau red at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
To the within	To t	M	29b. Signature and title of certifler Machan Hobby	~D	29c, Licens	e number	_	Date signed (Mon	
			30. Name and address of person who completed cau	, , , , , , , , , , , , , , , , , , , ,	, ,		ABBLY		
13H-C				Registrar's Signature	EANTIE	TAM ST	REET HI	19 EKCTUWA	J MARYLAND
	Sta Registr		JUL 1 0 2007		health				
DUMU 1	7 Pov 1/2	201		men H. A					

			1 - For State Registrar	State of Ma	-	epartment Certificate				Reg. No.	07	2338+
	Physici	on	Decedent's Name (First, Middle, La	st)					2. Date of Month	Day	Year	3. Time of Death
	/Medic		JAMES	KENNA	RD	HUDSON			JULY	4	2007	1:35 PM
	Examin		4a. Facility Name (If not institution, give					ocation of	Death		nty of Death	
			11568 WORCESTER	HWY.			SHOW				WORCES	
	Funeral Director		5. Social Security Number 214-28-3270 Usual Residence of Decedent	Sex 7. Age	(In yrs. last birth	Months		If Under 24 Hours	Min. 8. Date of (Month, MARCH	Birth Day, Year) 30,1929	9. Birthi Coul MA	place (State or Foreign ntry) RYLAND
	and will		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	/ary:	ŏ	MADVI AND HODGE	CORED	CHOL	UZT T						1 X Yes 2 □ No
	28a	ect	MARYLAND WORCE 10e. Street and Number	SIEK	SHOW	10f. Zip (Code			10g. Citizen o	of What Cour	ntn/?
3	with with	Funeral Director	11568 WORCESTER	עווע			21862)			USA	,
-	18 23	era	11. Marital Status	12. Was Decedent E	ver in U.S.				n? (Specify Yes or		ace - Americ	can Indian
_ [Itan Iner	占	1 Never Married 2 Married	Armed Forces?		If Yes, specif	ty Cuban,	Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	8	lack, White,	
5	irs a	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:]		1 ☐ Yes 2	X) No	Specify:		Spec	ify: WE	HITE
3-003e	within /2 nours atter death with the Maryland ene. Than "natural", or Itams 23a or 28a-f show he Madical Examiner must be notified at	ed	15. Decedent's E	ducation	16a. D	ecedent's Usual	Occupation	on		16b. Kind of	Business/In	ndustry
2	Vied C	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5-		Give kind of work ife. DO NOT use	c done dur e retired)	ring most o	of working			
7	The series	E	10	College (1-40) 34	7	MECHAN	IC			AUT	OMOBII	LE
<u> </u>	be flied within 72 hours after death with the Marylan tal Hygiene. Ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show evant, the Madical Examiner must be notified at	(D)	17. Father's Name (First, Middle, Last)			1:	8. Mother's	s Name (First, Midd	lle, Maiden Sum	ame)	
ā	should be nd Mental marked c	To B	JAMES	N. H	UDSON			GLA	DYS	CAMPB:	ELL	
<u>a</u>	should and Men s marke umatic		19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street and	d Number	or Rural Route Nur	nber, City or Tow	m, State, Zip	Code)
	and 2 ealth a n 27 ls		KANDIS L. LAYNE/I	AUGHTER	P.C	. BOX 1	61, 5	SHOWE	LL, MARYI	AND 218	62	
ַ אַ	- I a ≃	3	20a. Method of Disposition		20b. Place of D	isposition (Name crematory or oth	e of ner place)		Date	20c. Location	n - City or To	own, State
Ë,	rages nent of int: If its iry or o		1 Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Special		1	VILLE CE		RY 7	//7/07	BISHO	PVILL	E, MARYLAND
Baitimo	mit.		21. Signature of Juneral Service Lice		~	22. Name and						
Ď	Depa Impo any i		1 Whales V	Votant	201	HASTING	S FUN	NERAL	HOME, SE	LBYVILL	E, DE.	. 19975
	Physician /Medical Examiner		23a. Pant Later the disease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line a. Metc.	the death. Do no e. Stotic Co consequence of	recinoma	W 6	. W.	ardiac or respiratory		6	Approximate Interval Between Onset and Death
0/00,	To the hospital or Attantum Prinstrian; The taw requires that the death certificate be executed within 24 hours afforded: After this certificate has been signed by the attending physician and To tha Funaral Director: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	с.	consequence of)							
O. DOX O	sicials: The law requires man me dearn cermins certificate has been signed by the attending phrector, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 □Ectopic pre 5 □ Other (spe					Date of deliver	ery Day Year
cords, r	quires inat n signed b uld be deta	ρ	Part II. Other significant conditions	ontributing to death bu	t not resulting in t	ne underlying ca	use given	in Part I.		d tobacco use co ∃Yes 2□No	ntribute to the	he cause of death? pably 4 □Unknown
3	s bee	Completed							24a. W		. Were auto	opsy findings available
ב ז	te ha	E O							— au pe 1 ☐ Yes	topsy rformed?	death?	mpletion of cause of 2□ No
NI G	tifical lor, p	0	25. Was case referred to medical					6. Place o	f Death (Check on)		1 1 1 65	2 140
>	s cer	0	examiner? 1 □ Yes 2 □ N o	Hospital:	t 2□ER/Outp	atient 3 DOA	Other			sidence 6 C	ther (Specif	(v)
	th. th. : After thi s funeral (ıtlon; T	27. Menner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day		and the same of th	c. Injury a Work?		28d. Describ	e how injury occ		,
DIVIS	in the hospital of Attaining ringstrian; the within 24 hours after death. To that Funaral Director: After this certificate ha & mpletely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be determined		ry - At home, farm (Specify)	, street, factory,	office			(Street and Nur Town, State)	nber or Rura	al Route Number,
	e nosput 24 hours a Funara letely fille	edical (29a. Certifier Check only one) Certifying Pt	nysician: To the best of niner: On the basis of and manner stat	examination and/	death occurred a or investigation, i	t the time, in my opin	date and lion, death	place, and due to the occurred at the time	ne cause(s) and r e, date and place	manner as s e, and due to	tated. o the cause(s)
	within To th	×	29b. Signature and title of certifier			29c.	License n	number		29d. Date sign		
_	Cles		Veto XAKLIT	- CIM &			3061	19		7/5/	2007	7
9	5/2		30. Name and address of person who Peter S. Abboth		ath (Item 23a) (Ty	rpe, Print)	City	BI	Jel Suite	1 Beal	inm	congland 21811
Ī	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 6	32. Registra	r's Signature	Saget 1	,	t				

			For State Registrar	State of	Maryland	-	artment of F		Mental Hy	/giene Reg. No.	7 7	9.3	20
	Physici	an	1. Decedent's Name (First, Middle						2. Date of D Month JULY	eath	007 ^{Year}		of Death
	/Media		CHARLES		OLLAND							4:16	A M
Ž.	Examin	ner	4a. Facility Name (If not institution WASHINGTON A	. 0	er) OSPITAI		4b. City, Town, o	r Location of Death PARK	1		ty of Death		
	Funeral Director		5. Social Security Number 579–20–8259		Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth ay, Year) 10 192	9. Birth	place (State	or Foreign
(5)	P .		Usual Residence of Decedent		T. 10. 01.								
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In arked other than "natural", or items 23a or 28a-f show imaric event, the Madical Examiner must be notified at	7	10a. State 10b. County			, Town or Lo						10d. Inside 1 ∏ Ye	City Limits es 2 ☐ No
	the M 28a-f otifie	ect	MD PRINC	E GEORGE'S	HYA	ATTSVI	10f. Zip Code			10g. Citizen o	f Milat Co.	21	
	with i	Funeral Director	3202 TOLEDO	PLACE # 20	2		20782			U.S.A.	what Cou	ritry?	
	ns 23 mus	era	11. Marital Status	12. Was Decede	ent Ever in U.S	6. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or N	o- 14. Ra	ace - Ameri		
٥	after or iter		1 ☐ Never Married 2 ☐ Mari	Armed Force	□ No ARI	4Y I	lf Yes, specify Cuba 1 □ Yes 2 █️No		o Rican, etc.)		ack, White	etc. LACK	
000	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		TLI Yes ZLANO	Specify:		Spec	ify:	LILXOIC	
ה	72 h "natu dical	Completed		t's Education st grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	king	16b. Kind of	Business/II	ndustry	
V	within	d m	Elementary/Secondary (0-12)	College (1-4	or 5+)	lire. I	SPECIAL			G	OVERN	MENT	
7 01	Hygie ther i		17. Father's Name (First, Middle,	Last)			DIHOIM	18. Mother's Nan	ne (First, Middle				
0	ould be Mental arked o	To Be	WILLIAM HOLLA	ND				CORINN	A BROV	IN	,		
<u> </u>	2 shoul and M is marl	-	19a. Informant's Name/Relations	hip (Type. Print)	= 1	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Num	ber, City or Tow	n, State, Z	p Code)	
Ž	1 and 2 Health a tem 27 is	ľ.	ERVINA BLAND/	SISTER		3202	TOLEDO PI	# 2 0 2 H	YATTSVI	LLE,MAR	YLANI	2078	2
nore	of of		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		ate C6	emetery, crei	sition (Name of matory or other place	į	Date	20c. Location	,		T A NOTA
Dalillino	permit. Pag Department Important: I any injury c	10 3	21. Signature of Funeral Service		I MD	22	ANS CEME? 2. Name and Addre 474 LANDO	ss of Facility J.		KINS FU	INERAI	, MARY HOME 2078	
3			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cau	ised the death							Approxim Interval B	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	KI	na	I Fa	ure				Onset and	1 Death
	Examiner		Due to (or as a consequence of):										
		Je.	Sequentially list conditions, if any, leading to immediate cause. Eighter Underlying										
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
,00/	e exe ian ar uriai-t		resulting in death) Last	Due to (or	as a consequ	ence of):							
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Ď XO	iclan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregnai		7E-41			23d. D	ate of deliv	ery	
٥ د	he deatl the atte	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of de		Ectopic pregnancy Other (specify)			N	/lonth	Day	Year
ŗ.	that the ed by detac		Part II. Other significant condition	ons contributing to deat	th but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of	f death?
cords,	uires r sign lld be	d by	Endst	ces rei	ml	Star	Ivre.	CLL	1 🗆	Yes 2 No	3∏ Pro	bably 4	nown
5	w req	Completed	DIMILIS	mellet	4 J.	/ • •	,		24a. Wa	s an 24b	. Were aut	opsy finding	s available
ב	The la e has age 2	Ĕ	- TO Da Po	" CUP					auto peri	opsy formed?	prior to co death?	ompletion of	cause of
VII.			25. Was case referred to medica	ı				26. Place of Dea	1 Yes		1 ☐ Yes	2[4]No	
	Physician: this certifica	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	oatient 2 □ E	ER/Outpatier	nt 3 DOA Oth	or.		sidence 6 🗆 O	ther (Spec	ifv)	
5	ding Physician: h. After this certific funeral director,	T:U	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of (Month,	Injury Day Year)	28b. Time o	f 28c. Injur Wor			how injury occu	- ' '	-77	
	Attending r death. ector: After by the funer	atic	2 ☐ Accident investi	gation			M 1 □	Yes 2 □ No					
	al or Att s after de al Direct	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 28e. Place of building	f injury - At hoi i, etc. <i>(Specify</i>	me, farm, str)	eet, factory, office		28f. Location City or To	(Street and Nun own, State)	nber or Rui	al Route Nu	imber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the be Examiner: On the bas and manne	is of examinat	vledge, deat ion and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and r e, date and place	nanner as e, and due	stated. to the cause	e(s)
	To th withir To th comp	Me	29b. Signature and title of certifie	20	λ	à	29c. Licens	e number		29d. Date sign	ied (Month	, Day, Year)	\sim

State Registrar

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State of Maryland / Department of Health and Mental Hygiene 1- State Amend #18, 7-9-07, per FHDR, HCHD, time ate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROBERT JAMES 9:30 PM 07 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 7, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☑ M 2 ☐ F Yrs. Washington, D.C. 1930 76 Director 577-36-1528 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Director Elkridge MDHoward 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 7815 Oxford Drive #B USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Clinic Director 17. Father's Name (First, Middle, Last) 18. Mether's Name (First, Middle, Maiden Surname) EL1zabeth Teresa Adamson Be h and Mental F Raymond Thomas Holden ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health a tem 27 ls Patricia Holden/wife 7815 Oxford Drive #B Elkridge, MD 21075 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State Chesapeake Crematory 07/09/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service License Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Gastrointestinal Bleeding /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a present to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Severe Anemia Due to (or as a consequence of Examine The law requires that the death certificate be executed the burial-transi Myelodysplasia and Due to (or as a consequence of): Box 68760. Physician/Medical Hepatocellular Cancer IF FEMALE: 23c. if yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetai death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 Hypertension, COPD, Emphysema, Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No performed? Yes 2 X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one Hospital: 1 🔀 Inpatient Other: 1 Yes 2 No ဠ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 XNatural 2 ☐ Accident ours after death.

neral Director: A
filled in by the fi 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier DG4220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2)02 5755 CEDAR LANE, COLUMBIA, MD 21044 JUAN CABRETRA, MD 31. Date filed (Month, Day, Year) State Registrar 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician 26 FAYE RICHARDSON HOWELL JUN 2007 5:45 A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗙 F Yrs. Director 81 12/26/1925 Maryland 219-12-4278 Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? With 12400 Greenhill Drive 20904 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or item any injury or other traumatic event, the Medical Examinat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ◯ Widowed 4 □ Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Writer/Editor U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Benjamin Baker Alice Dove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Richardson-Daughter 634 Goldsborough Drive, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 07/03/2007 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Lices 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** INTRACEREBRAL HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. certificate be Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 😾 No 1 Tyes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: Alter Injury 1 XNatural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 2007 MI MD-417788 (PA) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 SAMUEL D. CRITIDES. JR CDR MC 31. Date filed (Month, Day, Year) edistrar's Signature State JUL 05 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year William Stephen Jackson, Sr. /Medical 26, June 2007 7:55 A 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11710 Mordente Drive Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 ☐ F Director <u>426-70-3459</u> 73 Dec. 5, 1933 Rome, GA Usual Residence of Decedent with the Maryland ehow. 10a. State 10b. County 10c. City, Town or Location rthen "natural", or items 23a or 28e-f ehov tre Modical Examiner must be notified at 10d. Inside City Limits Director MD Prince Georges Clinton 1 T Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11710 Mordente Drive filed within 72 hours after death Funeral U.S. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Maryland 21215-0036 þ 3 X Widowed 4 □ Divorced 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pages 1 and 2 should be filed went of Health and Mental Hygie ant: if Item 27 is marked other f Manager, Circulation The Washington Times other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ٥ David Jackson Mabel Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernedette S. Jackson / Daughter 11710 Mordente Drive, Clinton, MD 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If eny injury or once. 4 □Donation 5 □ Other (Specify) George Wash. Cem. 7/3/2007 Adelphi, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and D Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Attending Physician: The law requires thet the death certificate be executed ed by the ettending physicien and detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? been si Completed 2. No 3 Probably 4 Unknown After this certificete hes funeral director, page 2 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 Yes 2 No Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural nours after death.

nerel Director: After filled in by the fun 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide ö To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely i 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46046 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 05

2007

1. Decedent's Name (First, Middle, Last) Eugenia 4a. Facility Name (If not institution, give st		menez			2. Date of D Month	Day		3. Time of Death	
		menez						73 .	
4a. Facility Name (If not institution, give si	treet and number)				July	4, 4	007	11:13 P	
	,		4b. City, Town, or	Location of Death	_	4c.	County of Dea		
12500 Stratford Ga 5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	Silve If Under 1 Year Months Days	r Spring If Under 24 Hrs. Hours Min.	8. Date of B	irth Day, Year)	9. Bir	gomery Inplace (State or Foreign Juntry)	
215-33-5999		70 118.			Nov. 1	5, 19	36 _{E1}	Salvador	
10a. State 10b. County	10c. 0	City, Town or Lo	cation					10d. Inside City Limit	
Maryland Montgom	ery	Silv	ver Sprin	g		10a, Citiz	zen of What Co	1 ☐ Yes 2% N	
12500 Stratford		9		20904				alvador	
11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:								
(Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. I	kind of work done of DO NOT use retired	ation during most of work l)	ing	-		·	
		ног	memaker	40.44.0	· /=			e 	
19a. Informant's Name/Relationship (Typ	ne. Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Num	ber, City o	r Town, State, .	Zip Code)	
Domingo Jimenez/Hu	sband	12500) Stratfo	rd Garder	Drive	, Sil	ver Sp	ring, MD 2	
20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crei	matory or other plac	metery Ju	ly 14,				
21. Signature of Funeral Service License	De 5			ss of Facility Collins	Funera	1 Hom	ne Inc.		
disease or condition resulting in death)	Due to (or as a conse	equence of):	l Adenoca	rcinoma				1 Year	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2	23d. Date of de Month	livery Day Year					
Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause give	en in Part I.					
					aut per 1⊡ Yes	opsy formed? 2⊠No	prior to death?	utopsy findings availa completion of cause o s 2 □ No	
examiner?	ospital:	DEB/Outpation	oth	er.			о Пои — 10	***	
27. Manner of Death	28a. Date of Injury	28b. Time o						эспу)	
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 1 ☑ Natural 5 ☐ Pending investigation 6 ☐ Could not be determined	28e. Place of injury - At	home, farm, str	M 1 🗆		28f. Location City or T	(Street an own, State	d Number or R)	ural Route Number,	
29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of my kiner: On the basis of examiand manner stated.	nowledge, deat ination and/or in	h occurred at the tir evestigation, in my o	ne, date and place, pinion, death occur	and due to the	e cause(s) e, date and	and manner a I place, and du	s stated. e to the cause(s)	
29b. Signature and title of certifier			29c. Licens				e signed (Mon		
Jenn Alra	mun MD		555				_		
	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number 12500 Stratford 11. Marital Status 1	Usual Residence of Decedent 10a. State 10b. County 10c. County	215.—33.—59.99 Waryland Montgomery 10e. City, Town or Le Maryland Montgomery 12500 Stratford Garden Drive 11. Marital Status 1	15. 33. 5999 10c. City, Town or Location 10c. State 10c. County 10c. City, Town or Location 10c. Street and Number 12500 Stratford Garden Drive 12. Marietal Status 1	200 10c. City, Town or Location 23. Part Enter the disease, or complications find caused the death. Do not enter the mode of dying, such as cardiac or respiratory in least) Last 23. Part Enter the disease, or complications find caused the death. Do not enter the mode of dying, such as cardiac or respiratory in least) Last 23. Part Enter the disease, or complications find caused the death. Do not enter the mode of dying, such as cardiac or respiratory in least) Last 24. Was decedent pregnant in the past 12 months? 12 lives in last security in general and including a contributing to death but not resulting in the underlying cause given in Part I. 12 lives in the contributing to death but not resulting in the underlying cause given in Part I. 25. Disconting and contributing to death but not resulting in the underlying cause given in Part I. 25. Disconting and contributing to least or large, death occurred at the time, date and place and due to the floring, dec. 26. Place of Describing, flory or large floring placed in the past 12 months? 26. Place of Input part 26. Place of Describing in death) 26. Place of Describing in death 26. Place of Describing in the underlying cause given in Part I. 26. Place of Describing in the underlying cause given in Part I. 26. Place of Describing in the underlying cause given in Part I. 26. Place of Describing in the underlying cause given in Part I. 26. Place of Describing in the underlying cause given in Part I. 26. Place of Describing in the underlying cause given in Part I. 26. Place of Describing in the underlying cause given in Part I. 26. Place of Describing in the underlying cause given in Part I. 26. Place of Describing in Part 26. Place of Describing in Part 26. Place of Describ	20. State 10b. County 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. State 10b. County 10c. City, Town or Location 10c. Street and Homber 12c. State 10b. County 10c. City, Town or Location 10c. Street and Homber 12c. Was Decedent Ever in U.S. Armsel Forces 10c. City, Town or Location 10c. Street and Homber 10c. City, Town or Location 10c. City, City	23. Seption Downward		

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Š.	10		Registrar 1. Decedent's Name (First, Middle, Li	ast)			tinoa		Jean	-	2. Date of De	Reg. No.		3Time of Death
	Physici		· ·	ckson			Month 6/24					O7	Year	1140 P ^M
	/Medio		4a. Facility Name (If not institution, gi					4b. City, Town, or Location of Death					County of Death	
			Holy Cross Hosp	ital				S	ilver	Spr	ing	l M	lontgome	ry
*	Funeral			Sex 7.4 1 X M 2 □ F		last birthday)	If Unde	T 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth	nplace (State or Foreign intry)
~ 20	Director		376-36-3981	TESTIVI ZUF	64	Yrs.					5/17/	1943		hington, DC
	and www.		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Maryl f sho	to	MD Prince	George's		T.	andov	0 T						1X Yes 2 No
	r 28a	irec	10e. Street and Number	ocorge 5				p Code				10g. Citi.	zen of What Cou	untry?
	th with	a D	2207 Matthew Hen	son Ave					2078.	5			USA	
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural"; or items 23a or 28a-f show ont, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Deceder Armed Forces		.S. 13.	Was Dece	edent of Hi	spanic Ori	gin? (Spo	ecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White	
36	or it		1 ☐ Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give	¶ No		1 ☐ Yes		Specify:		,			
ő	hours tural' al Ex	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	s:	16a. Dece	dont's He	ial Occup	ation				Specify: B1a	
15	in 72 1 "nat ledic	olete	15. Decedent's B (Specify only highest gi	rade completed)		(Give	kind of w	ork done d use retired	during mosi)	t of work	ing	100. Kii	nd of business/i	ndustry
212	withi	mo	Elementary/Secondary (0-12)	College (1-4o	r 5+)			ocess					Gov	't
br	should be filed within and Mental Hygiene. s marked other than umatic event, the Me		17. Father's Name (First, Middle, Las		-				18. Mothe	er's Name	e (First, Middle,	, Maiden	Surname)	
ılar	should be and Mental semarked our umartic eve	To Be	Ralph Raymond Te	Ralph Raymond Terrell						gare	t Jack	son		
Maryland 21215-0036		9 8	19a. Informant's Name/Relationship Jamesanna Jackson			19b. Mailii 2207	ng Addres	s (Street a	and Numbe	er or Rur			r Town, State, Z	
	1 and 2 Health em 27 i	18		mile	1								ver, MD	
Baltimore,			20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 [☐Removal from Stat	e 206. F	Place of Dispo cemetery, crea	nsition (Na matory or	me of other plac	e)		Date	20c. Lo	cation - City or T	Town, State
ŧ	t. Pa rtmen rtant;		4 □ Donation 5 □ Other (Spec		Ft.	Linea	1n C	emete	ry 6	5/29	42007	Bre	ntwood Funeral	MD
Bal	permit. Page Department of Important: If any injury or once.		21. Signature a Functor Service Liv	see										
	2 - 100		23a. Part1. Enter the disease, or cor	nplications that caus	ed the deat								MD 2078	Approximate
	Physician	V.	shock, or heart failure. List only Immediate Cause (Final			1						,		interval Between Onset and Death
	/Medical		disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of):											
K.	Examiner		0	· ·		al Pne	umon	itis						
**. :	P ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Districts (or s										
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		Artery Disease									
8760,	be ex ician burial			,		uence on. 1 Fail	1176.0							
687	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the buriat-transit	dical		d. Acute	кепа	ıı ralı	ure							
Box (leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e pf <u>pr</u> egna	ancy					***		23d. Date of deliv	verv
ğ	death atter	icial	in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant	at time of d		∃Ectopic p ∃Other <i>(s</i>	regnancy pecify)					Month	Day Year
Ö	at the de by the a tached	hys	9 ☐ Unknown	9□Unknown										
s, P	res thai igned b	by P	Part II. Other significant conditions Hypertension	contributing to death	but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
or Vital Record	w require been si should b										10,	Yes 2[□No 3□Pro	bably 4 Unknown
ec	law as b 2 sl	Completed	Diabetes Mellitus	3							24a. Was		24b. Were aut	opsy findings available ompletion of cause of
=		Con	Hypernetremia									rmed?	death? 1 ☐ Yes	2 🙀 No
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hoopital				011		of Death	Check only o	ne)		
or	this aldir	ဥ	1 Yes 2 No 27. Manner of Death	Hospital: 1 IXInpa 28a. Date of Ir		ER/Outpatier 28b. Time o	-		4 L Nu				Other (Spec	ify)
n	ding F h. After funer	jon	1 □ Matural 5 □ Pending	(Month, E		Injury	M	28c. Injury Work	/aπ ⟨? Yes 2∐I		28d. Describe how injury occurred			
Division	ten leat tor: the	ficat	3 Suicide 6 Could not b	28e. Place of i	njury - At ho	ome, farm, str					28f. Location /	Street an	d Number or Ru	ral Route Number,
<u>S</u>	<u>=</u>	Certification:	4 ☐ Homicide determined	building,	etc. (Specif	(y)					City or Tov			,
	Hospital 24 hours a Funeral stely filled		29a. Certifier 1 Certifying P	hysician: To the besi	at of my kno	wledge, deat	h occurred	d at the tim	ne, date an	id place,	and due to the	cause(s)	and manner as	stated.
	To the Hos within 24 hd To the Fun completely	edical	one)	aminer: On the basis and manner	or examina stated.	LION ANG/OF IN				un occur	red at the time,	date and	piace, and due	to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	1				c. License)5514					e signed (Month	
	(.0)		· Carry	1/1				13314	·			JUNI	E 24, 20	
R	VO)			completed cause of		, ,		רוד דיי	DOAD	077	WED CO	OTKT C	MADVI A	ND 20010
-	Sta	te.	Delroy Peter 31. Date filed (Month, Day, Year)		trar's Signa		KE91	GLEN	KUAD	Dii	VER SPI	ALING,	MARYLA	ND 20910
	Registr		HH 0 6 2007			(3.11)								

			1- State of Maryland Registrar	/ Department of Health and N Certificate of Death	lental Hygien Reg. N	0007 30001				
100	Physicia		Decedent's Name (First, Middle, Last) TANIA JOHN	SON-ALLEN	2. Date of Death Month JUNE 23	3. Time of Death 2:50 P				
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 3205 75th AVENUE # 102	4b. City, Town, or Location of Death LANDOVER		PRINCE GEORGE'S				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea JULY 10 1	9. Birthplace (State or Foreign Country) WASHINGTON, DC				
	land on the state of the state		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits				
	e Mary ia-f sho tiffied a	ctor	MD PRINCE GEORGE'S LAN	DOVER		1 Yes 2 □ No				
	with th a or 28 t be no	Director	10e. Street and Number 3205 75th AVENUE #102	10f. Zip Code 20785	10g. C	Citizen of What Country?				
	death	Funeral	11 Marital Status 12 Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.				
39	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 [XiNo Specify:	riidan, cio.)	Specify: BLACK				
21215-0036	n 72 hor "natura edical E	Completed	(Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)	16b.	Kind of Business/Industry				
212	d withi giene. er than	Somp	Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs	ACCOUNT MANAGER		PRIVATE				
and	ld be file ental Hy ked oth	To Be (17. Father's Name (First, Middle, Last) ROBERT DAVIS		(First, Middle, Maide LY PARKER	en Surname)				
Maryland	nd 2 should lith and Men 27 is marker r traumatic	-	19a. Informant's Name/Relationship (Type. Print) ANTHONY ALLEN/HUSBAND	19b. Mailing Address (Street and Number or Run 3205 75th AVENUE # 102						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Puriol 2 Cromation 2 Permoval from State	ce of Disposition (Name of netery, crematory or other place) C.LINCOLN CEMETERY 6/30		Location - City or Town, State ENTWOOD, MARYLAND				
Balti	permit. Departm Importa any inju		CINS FUNERAL HOME ER, MARYLAND 20785							
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events)	Approximate Interval Between Onset and Death						
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit.	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Due to (or as a consequence of the con		23d. Date of delivery Month Day Year					
Д.	juires that t n signed by ild be detac	þ	Part II. Other significant conditions contributing to death but not resulti		tobacco use contribute to the cause of death?					
Division or Vital Records,		Completed		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No					
Vita	Physician: The this certificate har ral director, page	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other	(Check only one)					
on or	ding Ph n. After th funeral	tion: To	27. Manner of Death 1 ★Natural 5 Pending (Month, Day Year)		me 5	6 Other (Specify) jury occurred				
Divisi		Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 5 City or Town, State) 28f. Location (Street and Number of City or Town, State)							
	the Hospital or hin 24 hours afte the Funeral Dir npletely filled in I	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination and manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)				
	Tie		20. Name and address of names who completed over at death (1) and	D53530		JUNE 27 2007				
C	(15)		30. Name and address of person who completed cause of death (Item 2 SIDNEY DY M.D. 624 N. BROADI	WAY BALTIMORE, MARYLANI	21215					
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature 33. Regist	re &						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) **Physician** ATHURIMA 23:50 2007 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** GROVE ADVENTIST ROCKVILLE HOSPITAL MARYLAND MON IGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 3 3 4 6 7 1 3 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M **X**□ F NONE MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events." 10c. City, Town or Location 10d. Inside City Limits 10a. State ROCKVILLE 1 Yes 2 □ No Director MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number DRIVE 2087 20036 NNABAR Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify <u>≽</u> BLACK 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be KATHURIMA ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. MOTHER CINNABAR KATHURIMA GAITHERSBURG, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriat 2 X Cremation 3 □Removal from State CYCLE 8 TALL RIVER, NC 4 □ Donation 13/2007 5 ☐ Other (Specify) 22. Name and Address of Facility 10 9901 MEDICAL CENTER DRIVE, KOCKVILLE, MB 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PREMATURIT EXTREME /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown Day Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 2 s 1☐ Yes To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 ☐ Yes Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28b. Time of 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 43666

State Registrar

DHMH 17 Rev 1/2001

Mila =

BERT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SIMMONS, MO

9901

egistrar's Signature

ORIGINAL

MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850

J.B.X

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:06 A_M July 4 2007 Gene Beverly Keller /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 12038 Ronnie Drive Hagerstown Washington County If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 X M 2 ☐ F Days Hours Min Yrs 76 Director 9 <u>215–26–8623</u> Aug 1930 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits 27 is marked other than "natural", or Items 23s or 28s-1 show treumstic event, the Medical Examinat must be notified at Maryland Washington 1 ☐ Yes 2 ☑ No Director Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 12038 Ronnie Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZXNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Control Room Supervisor Cement Company 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Frederick Keller Lena Walker Heflin 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12038 Ronnie Drive Hagerstown Maryland 21742 Evelyn A. Keller wife 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Smithsburg Cemetery July 9 07 Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Musto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) tren /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced in the control of Due to (or as a consequence of) Examine The law requires that the death certificate be executed ettending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ā 3 Probably 4 Unknown should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cete has l certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 25 mpleted cause of death (Item 23a) (Type, Print) 05H-15 5 111 my IIIIU 31. Date filed (Month, 1991) 32. Pagistrar's Signature State Registrar

			State State Amend #25 per PHY	of Marylan 7S/FH 07-	d / Depa -09-20(rtment of H	lealth a Death	ınd Men	tal Hyg	iene eg. No.	007	2330	
90	-49		Decedent's Name (First, Middle, Last)					2. [Date of Deat	h	2 0 1	3. Time of Death	
	Physicia		Alfred Randall Kaleo								Year 2007	7:25 P ^M	
2 30	/Medic Examin		4a. Facility Name (If not institution, give street and n					4c. County of Death					
魔			Frederick Memorial Hos	Fred	erick			Frederic					
Г	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. [Min. (Date of Birth Month, Day,	Year)	9. Birthp Coun	lace (State or Foreign try)	
18	Director		217-68-4990	52	Yrs.		7,104.10	00	t. 4,	1955	Mary!		
	w		Usual Residence of Decedent 10a. State 10b, County	10c, Cit	v. Town or Lo	cation			-		1	0d. Inside City Limits	
	/laryli f sho ed at	or	Maryland Frederick		There							1 X Yes 2 ☐ No	
	the N 28a-	Directo	10e. Street and Number		Thuri	10f. Zip Code			1	0g. Citizen of	What Coun	itry?	
	with 3a or 1 be		203 North Carroll St	treet			788				ted St	•	
	ms 2%	Funeral	11 Marital Status 12. Was De	cedent Ever in U.	.S. 13. V	Vas Decedent of Hi	ispanic Orig	gin? (Specify	Yes or No-	14. Ra	ce - Americ	an Indian,	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by Fur	1 Never Married 2 Married 1 Yes, 0	Forces? s 2X No Give		f Yes, specify Cuba □ Yes 2☑XNo	ın, Mexican, Specify:	i, Puerto Rica	ın, etc.)		ick, White, i fy: Whit		
5-0036	72 hour natural lical Ex	eted k	15. Decedent's Education (Specify only highest grade completed	15. Decedent's Education 16a. Dec				of working	16b. Kind of Business/Industry				
2121	within ene.	Completed		(1-4or 5+)	life. L	OO NOT use retired Carpente))			Consti	cuctio	nn .	
0	Hygi Other ent, tl	Be C	17. Father's Name (First, Middle, Last)		L			r's Name <i>(Fir</i>	rst, Middle, N	Maiden Surna		,11	
Maryland	Mental Merked o	To B	Alfred H. Kaleo					F1c	orence	Capps			
ary	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street a	and Number	er or Rural Ro	ute Number	, City or Town	, State, Zip	Code)	
	and 2 salth n 27 i		Brenda Kaleo / Wife			North Car	roll S	St., T					
ore	es 1 a of Hea fitem rrothe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from	ion 3 D Bemoval from State cemetery, crematory or other place)						Date 20c. Location - City or Town, State			
altimore,	Pages ment of l ant: If its jury or o		4 ☐ Donation 5 ☐ Other (Specify)	Res		Memoria		/6/200				Maryland	
Ball	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licensee	114157	(-)	Name and Address 1621 Opo	ssumt	own Pi	ke, Fi			-	
	2		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dwing, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.										
	Physician		Immediate Cause (Final disease or condition									Onset and Déath	
	/Medical Examiner		resulting in death) Due to	o (or as a conseq	uence of)	and	rose	a	me	et	, dt	MD V.	
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	uence of):					104	1 lue			
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687	ficate physis the	edical	d						/ (
Box	leath certific attending p	III/M	230. Was decedent pregnant 4 🗀	outcome pf pregna		Catonia areamone				-	ate of delive	ery	
	The law requires that the death certifite has been signed by the attending to age 2 should be detached for use as	Physician/Me		gnant at time of d		Ectopic pregnancy Other (specify)				M	onth	Day Year	
, P.O	ires that the de signed by the a I be detached f	by Ph	Part II. Other significant conditions contributing to	death but not res	ulting in the ur	nderlying cause give	en in Part I.		23e. Did tol	bacco use cor	tribute to th	ne cause of death?	
Records,	w require been sig should b	ed b							1 🗆 Y	es 2⊡No	3 ☐ Prob	pably 4 □Unknown	
ပ္က	aw re	Completed							24a. Was a		. Were auto	psy findings available mpletion of cause of	
		mo					-		autops perfori 1□ Yes	med2 2 No	death?	2□No	
Vita	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?				26. Place	of Death (Cl					
>	hysic his ce Il direc	To		☐Inpatient 2☐			4 LI Nui	rsing Home	5 Reside	ence 6 🗆 Ot	her (Specif	y)	
בַ	tending Ph eath. tor: After th the funeral		27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Mo	te of Injury onth, Day Year)	28b. Time of Injury	Worl	k?		Describe ho	ow injury occu	irred		
Sio	ttend leath. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Pla	no of injury. At h			Yes 2□N		Lanation (G	1-0-4 (A /		al Davida Alvertar	
Division or	after of Direct of in by	Certification:	dotormined 200. Fla	Iding, etc. (Specil	fy)	eet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					ai noute Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To t 2 Medical Examiner: On the and many many many many many many many many										
	ro the vithin ro the	Me	29b. Signature and title of certifier			29c. Licens	e number	-1,0,	2	9d. Date sign	ed (Month,	Day, Year)	
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,	R		30. Name and address of person who completed ca	•			1			1 1	y 1		
	v		William Harper, MD	180 TJ	Drive,	Frederic	k, MD	21702	2				
	Sta Registr		31. Date filed (Month, 1941, Yelf) 9 2007 32.	. Pigistrar's Signa	I A	backer							

latthew Joseph I		1- For State	te of Maryland	/ Depa		Health a		Hygiene	g. No.	II
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Middle, MATTHE			NION			2. Date of Death Month June 30, 2	Day Year	3. Time of Death 0133 hrs
£		4a. Facility Name (if not institution, NB Kemp Mill Road			, or Location of De ring		4c. County of D Montgome	ry		
Funeral Director	- 1	5. Social Security Number 214-21-0754	ast birthday) Yrs.			e.	h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD			
Maryland 28a-f show any d at once.	jo		gomery	Town or Locati		Spring	7.		10d. Inside City Limits 1 Yes 2 X No	
th the Maryland 23a or 28a-f sho notified at ouce.	Director	10e. Street and Number 1933 Amberstone Court				10f. Zip Cod	20904	10	${f U}$. ${f S}$	·
er death wi	by Funeral	11. Marital Status 1 XNever Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced or Dates:			If Yo	es, specify Cu Yes 2X		14. Race - American Indian, Black, White, etc. Specify: Black		
21	mpleted	15. Decedent's Education (Specif Elementary/Secondary (0-12)	during me			retired)	16b. Kind of Business/Industry Lincoln Tech Institute			
2121 ild be fil Mental H narked event, i	Be	Clyde J. Kenion Karen E. Boland								State. Zip Code)
MD and 2 sho alth and 2 is m 27 is	Karen E. Kenion (Mother) 1933 Amberstone Ct., Sil								20c. Location - City or Town, State	
Baltimore, permit. Pages I a Department of He Important: If ite	0	4 Donation 5 Other Spe 21 Signature of Funeral Service	cify: 12	Ga	22. N	lame and Add		NOWDEN	L FUNERAL	Spring,MD HOME, P.A. le,MD 20850
Physician Medical caminer	1	23a. Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)		8	o not enter th					
B	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Lest Due to (or as a consequence of):								
be executed ician and urial - transit	dical Ex	events resulting in death) Last UNPENDED	d AMENDED							
6876C certificate nding phys	ŝÌ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant at		2 Fe	tal death her (Specify)	3 Ectopic pre	gnancy	23d. Date of de Month	livery Day Year
P.O. es that the gned by	ह	Part II. Other significant conditio		h but not re	esulting in the u	inderlying cau	se given in Part I.			te to the cause of death? Probably 4 Unknown
Records, The law requir	Completed							24a. Was a autope perfor	sy prio med? dea	re autopsy findings available or to completion of cause of th? Yes 2 No
ion of Vital tending Physician: eath. for: After this certif	To Be	25. Was case referred to medical examiner? 1 Ves 2 No 27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatient 28b. Time of I	3 DOA	Other Nu	rsing Home 5	Residence 6 🗸	
O Z E B B	Certification:	1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Homicide Natural 5 Pending Investigation 1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) NB Kemp Mill Road , Silver Spring								or Rural Route Number, City
0 - 3 5	Medical C	29a. Certifier 1 Certifying Phy	rsician: To the best of m iner: On the basis of exa and manner stated.	y knowledg	ge, death occur					
	¥	29b. Signature and title of certifier	W. W				cense number		29d. Date signed June 30, 200	(Month, Day,Year) 7
			ty Chief Medical E	xaminer	111 Per	n Street, E	Baltimore, MD	21201		
Sta Registr	ite ar	31. Date filed (Movil Day (eg)	2007 32 egistra	r's Signaty	Apple	120				

State Registrar DHMH 17 Rev 1/2001 OCME 2006

		For State Registrar 1. Decedent's Name (First, Middle, Las	State of Ma		ertificate of	Death	2 Date of Death	g. No.	3. Time of Death
Physicia /Medic		Ellis B. K	lioze				Month uly	3°, 2007° ar	7:05 A _M
Examine		4a. Facility Name (If not institution, give				or Location of Deat	th	4c. County of Death	
Funeral Director	3	Holy Cross Nursi 5. Social Security Number 6. Se 577-60-1933		(In yrs. last birtho	Months Days	If Under 24 Hrs		Montgomer 9. Birth	y place (State or Foreign P81and
Du ≱_	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town o	r Location				10d. Inside City Limits
ms 23a or 28a-f show	to	MD Montgom	ery	Burtons	ville				1 X Yes 2 No
23a or 28a ist be not	Funeral Director	10e. Street and Number 3415 Greencastle	Road		10f. Zip Code	0866		Og. Citizen of What Cou United Sta	
al', or ite	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S.	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ▼ No		Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	
he. han "natur e Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+		ecedent's Usual Occup live kind of work done e. DO NOT use retire Administr		orking 1	16b. Kind of Business/In	
and Mental Hygiene. Is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last) Solomon Klioze					me (First, Middle, M ebfield	faiden Surname)	
m 27 is marked o	ဥ	19a. Informant's Name/Relationship (7) Devorah K. Rubin	-		ailing Address <i>(Street</i>			City or Town, State, Zi	p Code)
Department of need important: if item 2 any injury or other once.		20a. Method of Disposition 1♥ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		sposition (Name of crematory or other pla Memorial G			20c. Location - City or T $01{ m ney}$, MD	own, State
importa any inje		21. Signature of Funeral Service Licens	see		22. Name and Addre Edward Sag 1091 Rocky	ess of Facility Funer 111e Pik	al Direct e Rockvil	ie ⁿ Md 2085	2
physician and leadical superior and physicien and physicie	edical Examiner	shock, or heart failure. List only of disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	consequence of):	d Deka	entia			Interval Between Onset and Death
O) 03	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	sy		23d. Date of deliving Month	rery Day Year
		Part II. Other significant conditions co	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco us						
has e 2	Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to co	opsy lindings available ompletion of cause of 22 No
rector,	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only one		
	tlon: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatien 28a. Date of Injury (Month, Day	t 2 ☐ ER/Outpa 28b. Tim Year) Inju	e of 28c. Inju	4 Nursing	Home 5 Resider 28d. Describe hor	nce 6 Other (Speci w injury occurred	ify)
al Director ad in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street, factory) 28l. Loca							al Route Number,
the Funerappletely fills	edical	(Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner state	examination and/o	r investigation, in my	opinion, death occ	urred at the time, da	use(s) and manner as ite and place, and due	to the cause(s)
To	Σ	29b. Signature and title of certifier	2			se number	29	d. Date signed (Month	Day, Year)
į.	}	30. Name and address of person who of	ompleted source of the	ath (Item 32a) /T		54566		11310+	
Stat Registra			2000 Aegistrar	's Signature	Chewyh	eaf Te	rva Co, Si	lversprin	9 MD20901

State Registrar

DHMH 17 Rev 1/2001

Solish

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David F. Coucil, MS 31. Date filed (Month, Day, Year)

			For State	State of Maryla		artment of H r <i>tificate of I</i>			ene	
le:		-	Registrar 1. Decedent's Name (First, Middle, Last	*)		timodio or i	Journ	2. Date of Death		3. Time of Death
	Physicia /Medic		ROBERTA R.	LEHMANN				July 2	2 2007	9:32P M
	Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	
lane.		- %	Caroline Hosp 5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Caro	TITE
	Funeral Director		213-30-0183	M 2 → F	73 Yrs.	Months Days	Hours Min.	(Month, Day, 9 / 26 / 19	Year) C	ryland
	land t		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary -f sho fied a	tor	MD Talbo	ot		Easto	n			1 21 Yes 2 □ No
	r 28a	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	th with	Funeral Director	116 Hughlett	Street		2:	1601		United	States
	r dea ems er mu	iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
980	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notitied at	by	1 ☐ Never Married 2 ☐ Married 3 🗹 Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:	,		hite
2	72 ho natur lical I	sted	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	ation during most of work	ina 1	16b. Kind of Business	/Industry
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7	lled w dygie her ti nt, th	S	12 17. Father's Name (First, Middle, Last)			Sales 1	18. Mother's Name			att ins.
and	d be fantal h	Be c	Robert Rosewa	Ci .			Alice		and on Juniano,	
Ž	shoul nd Me mark	2	19a. Informant's Name/Relationship (T	-	19b. Mailir	ng Address (Street			City or Town, State,	Zip Code)
M	and 2: alth ar 27 Is or trat		Kenneth Lehman	n/Son	304	Commerc	ce Stree	et, Huri	lock, MD	21643
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I	nemoval mom state		esition (Name of matory or other place	7/0/		20c. Location - City or	Town, State Maryland
altin	permit. Pa Departmen Important any injury once.	i	4 ☑ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License		22	Gift Re	ss of Facility		h Main S	
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.	_		ig, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC	FAIL	uke				12 hours
	/Medical Examiner		resuming in dealiny	Du to (or as a cons	sequence of):	95				48 hours
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Maligi	nant 1	reoplas	m of B	RAIN	191.9	Unknown
68760,	eath certificate be executed attending physician and for use as the burial-transit	EX	resulting in death) Last	Due to (or as a cons	equence of):	1	,			
387	cate physisthe b	edical		d						
	certifi nding Ise as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre	gnancy				23d. Date of de	livery
Box	death e atter	Physician/M	in the past 12 months? 1 □ Yes 2.■No	1□Live birth 2□F 4□Pregnant at time o		∃Ectopic pregnancy ∃ Other (specify)	/		Month	Day Year
P.O.	t the	hys	9 ☐ Unknown	9□Unknown						
	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions co	ontributing to death but not i	resulting in the u	nderlying cause give	en in Part I.	11		to the cause of death?
oro	requi	ted						I L Te	s 2 No 3 F	Probably 4 Unknown
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ita	stan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one		
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ono	ding F h. After funera	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe ho	w injury occurred	1
Visi	Atten r deat ector by the	ifica	3 Suicide 6 Could not be determined	28e. Place of injury - Arbuilding, etc. (Spe	t home, farm, str	reet, factory, office		28f. Location (Str City or Town	reet and Number or F	Rural Route Number,
Ö	oital or urs afte eral Dir illed in					b one was all at the at-				
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	(Check only 2 Medical Exam	vsician: To the best of my liner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my o	ppinion, death occur	red at the time, da	ate and place, and du	ue to the cause(s)
	To 1	Σ	29b. Signature and title of certifier	Besson	MysiciA	29c. Licens	e number		July 3 ,	
,			30. Name and address of person who c							
	Sta	te	31. Date filed (Month, Day, Year)	SSO, Jr. 1			., St. 1	Michael	, Md. 2	
	Registr		JUL 5 20	07 Acon	A A	and a				

		-	For State of Ma	arylan		artment of F <i>rtificate of</i>	Health and I <i>Death</i>	-	giene Reg. No		A
	- 5		Decedent's Name (First, Middle, Last)					2. Date of De	eath	1.01/	3. Time of Death
20	Physicia		Helen E. Lewis					Month	2	2007	8:20 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)				or Location of Death		40	. County of Death	4
			Salisbury Rehab+ Nurs		Ctr.		lisbur	4	(Nicon	
	Funeral		4 D M 0 M E		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8/24/1	th ay, <i>Year</i>	9. Birthp	lace (State or Foreign try)
	Director		219-20-8817	78	Yrs.			8/24/1	928	Mary.	Land
	and and	ł	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation				1	0d. Inside City Limits
	Maryl f sho	ō	Maryland Wicomico	Sal	lisbur	v					1 XYes 2 No
	the 28a-	Directo	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Cour	ntry?
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at		5972 Hobbs Rd.			21804			USA		
	deat	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Decedent of I	Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or No	D-	14. Race - Americ Black, White,	
	after or ite mine		1 Never Married 2 Married 1 Yes 2 X			1 ☐ Yes 2 🔀 No		, ,		Specify:	
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⊃ 1 7	n 72 l "nat edica	lete	15. Decedent's Education (Specify only highest grade completed)		(Give	e kind of work done DO NOT use retire	during most of world)	rking	100.7	KING OF BUSINESS/III	dustry
7	within 72 iene. than "na he Medic	Completed	Elementary/Secondary (0-12) College (1-4ors	5+)	Secre		•		Att	orney's C	ffice
100 d 2	filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)			-	18. Mother's Nar	ne (First, Middle	, Maide	n Surname)	
a n	lid be lental rked o	To B	George Burdett				Anna	Mae Your	nghe	im	
en L	2 should and Men Is marke aumatic	ľΞĭ	19a. Informant's Name/Relationship (Type. Print)		19b. Mail	ing Address (Stree	t and Number or Ri	ural Route Numb	ber, City	or Town, State, Zip	Code)
	and 2 ealth: n 27 I		Sandra Perdue/daughter				non Rd.,S			ryland 21	
He	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	20b. F	Place of Disp cemetery, cre	osition (Name of ematory or other pla 111 Memor	ace)	Date	20c. I	Location - City or To	own, State
七篇	Pa Int: Int:		4 ☐ Donation 5 ☐ Other (Specify)	Gar	rdens		: 7/6		Heb	ron,Maryl	and .
Balt	permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygic Important: If item 27 Is marked other any injury or other traumatic event, the		21. Signal re of Funeral Service Licensee	CSP	H 5	0110way 1 0110way 1 01 Snow 1	ineral H Hill Rd.	ome PA Salisbu	cv,	Maryland	21804
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	Physician [*]	2.5	Immediate Cause (Final	// -		` <	D	- 1 -		12	Onset and Death
	/Medical		reculting in death)	a conseq	uence of):	7	2	7		1	- Luis
100	Examiner		Sequentially list conditions b.	102	275	211	ey /	ne	4	وا' ب	Par-
	sit sd	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a curisey	uentes off:		J			1	
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Box	death certif e attending ed for use as	M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth	pf pregna	ancy	□Ectopic pregnan	01/			23d. Date of deliv	*
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or o	requi	Completed								7	
ec	e law e 2 st	삘						24a. Was	s an opsy formed2	prior to co	opsy findings available impletion of cause of
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ō		<u>۲</u>	27, Manner of Death 28a. Date of Inj	ury	ER/Outpatie 28b. Time			28d. Describe		6 □Other (Speci jury occurred	TY)
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Division or Vital Records,	Attend r death. ector: / by the f	ifica	0.500 11 11 11	jury - At h	ome, farm, s	treet, factory, office	•	28f. Location City or To	(Street	and Number or Run	al Route Number,
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	To the within 2	Mec	29b. Signature and title of certifier)		29c. Licer	nse number		29d. E	Date signed (Month,	Day, Year)
	F S F S		120 Str.	4 -		0:	2930	P	7	/3/117	
	100		30. Name and address of person who completed cause of	death (Iter	m 23a) (Type	e, Print)	1-1	1	1	1 seal	
	R		William H. Robins,	W-	D. &	200 G	Vic. Au	e. Ja	lis	bury, 1	ND & 1804
		ate		trar's Sign	ature					J.	
	Regist	rar	JUL 0 6 2007	a A	K A	wante)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** \mathbf{P}^{M} Frank Lupi 2007 7:51 Ju1v/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ceci1 Rising Sun 368 Connelly Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F 47 June 18. 1960 Pennsylvania Director 185-52-2054 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygient Department if Hean 23 Is marked other than "ratural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Cecil Rising Sun 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21911 USA 368 Connelly Road Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: à 3 ☐ Widowed 4 🔯 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 General Contractor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Lupi Marie Barcus ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Lupi/Ex-wife 1730 Trappe Church Road, Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7-11-2007 Ferris & Co. West Chester, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility T. Foard Funeral Home, P.A. I.S. Queen Street, Rising Sun, MD 21911 000 Approximate Interval Between Onset and Death beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1 Enter the disease, or complications to shock, or heart failure. List only one cause caused the each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): ed by the attending physician detached for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown cate has been signed by t , page 2 should be detach Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tyes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

Stephen NaylorDD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

augt

JUL

31. Date filed (Month, Day Year)

Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3c. Coo 7 7:48 for Coo 7			1 - For State Registrar	State of Maryland		artment of H			Reg. No		1340
S. Social Sociality Number of Sociality Number	/Medica	al .		Lovo		I		Month	Da S	F 505 C	3. Time of Death
100 Sales 100 County 100 City Town or Location 100 Indice of Cyru 100 Citis on all Months 100 City 100 Ci	Funeral	er	5. Social Security Number 6. S	7. Age (In yrs. las		If Under 1 Year	If Under 24 H	rs. 8. Date of Birn. (Month, Da	th y. Year)	9. Birthp Coun	ace (State or Forei
Secretary Control Programme Control Progra	3e-f ehow diffied at	ctor	10a. State 10b. County								0d. Inside City Limi 1X Yes 2 ☐ N
Specific Continues Specifi	23a or 2	ral Dire		t #1		2090			E1		•
Secretary Control Programme Control Progra	al', or iteme Examiner m	ବ	1 ☐ Never Married 2 ₹ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	13.					Black, White,	etc.
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The state of the s			Part II. Other significant conditions co	entributing to death but not resulti	ng in the u	nderlying cause give	en in Part I.				1.5
18315 JULY, 2, 2007	page 2 sho							autor	sy rmed?	prior to con death?	npletion of cause
18315 JULY, 2, 2007	un.: After this certile funeral directo	0	axamiher? 1 Ves 2 No 27. Ma ner of Death 1 Natural 5 Pending	1 K Inpatient 2 ☐ EF	b. Time o	f 28c. Injury Work	er: 4 □ Nursing v at c?	Home 5 ☐ Resid	dence)
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20 Norway and address of common who committed account of death (Norway 201) (Tour 201)	vith com	2	29b. Signature and title etertifier			183	15		JU	LY, Z	2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Physician LESCAULT JULY 2007 2:30 P ^M MTCHAEL. Τ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES GENERAL HOSPITAL PRINCE GEORGES CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. 60 Director 031-34-5079 24, 1946 MASSACHUSETTS Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show The Medical Examiner must be notified at 1 XYes 2 ☐ No Director PRINCE GEORGES CHEVERLY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3030 CREST AVE. 20785 r death U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 TYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: if Item 27 is marked other than ' AFL-CIO Elementary/Secondary (0-12) College (1-4or 5+) 5+ DEPUTY DIRECTOR SOLIDARITY CTR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD LESCAULT ELEANOR HAGGERTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any injury or other trau ELISABETH K. LESCAULT/WIFE 3030 CREST AVE., CHEVERLY, MD. 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 17-6-2007 RIVERDALE, MD. 21. Signature of Funeral Service Dicensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death one of dying, such as cardiac or respirator Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or injury to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medicai the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) exemine. 1/2 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 🗆 No 2 ER/Outpatient 3 DOA npatient After thi funeral date of Injury (Month, Day 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29d. Date signed (Month Day, Year) 29b. Signature and title of pertifier 29c. License number 303/8 VA only 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 **JAMES**

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 6 2007

3001 HOSPITAL DR., CHEVERLY, MD. 20785

CATEVENIS, M.D.

Meyers, Nona R. Baltimore, Maryland 21215-0036

			Please Ty State Amend Item 8 Registrar	ype or Print ir State of Maryl per fh,g87								7 2040
			Registrar 1. Decedent's Name (First, Middle, Last)			Jertinea	10 01 1	Jean	2. Date of D	eath		3. Time of Death
М.	Physici /Medic		Nona F	Rosella Mey	yers				July	3 Da	200 T	11:05 PM
)	Examin	er	4a. Facility Name (If not institution, give si	treet and number)		,		Location of Death	1	4c	. County of De	
_			Lions Center 5. Social Security Number 6. Sex	7. Age (In	yrs. last birth		oerla er 1 Year	na If Under 24 Hrs.	8. Date of Bi	rth	Allega 9. B	any irthplace <i>(Stat</i> e or Foreign
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Aryland 21215-0036 should be filed within 72 hours after death with the Maryland	at		10a. State 10b. County	10c.	City, Town	or Location						10d. Inside City Limits
e Mar	of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	Maryland Garrett		Gr	antsvi.						1 □Yes 2X No
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led w	Hygien ther the	ပိ	17. Father's Name (First, Middle, Last)			TORICHO.	T.C.L	18. Mother's Nan	ne (First, Middle	e, Maidei		J
and def	ed of) Be							Oester		•	
Maryland nd 2 should be file	and Me Is mark aumatio	은	Dennis Brenneman 19a. Informant's Name/Relationship (Type	oe. Print)	19b.	Mailing Addres	ss (Street	and Number or Ru		ber, City	or Town, State	e, Zip Code)
g 2 ^p	Health ar		Wanda Yoder/daughte	er	93	34 Mas	on-Di	xon High	way, Sa	lisb	oury, P	A 15558
= 8			20a. Method of Disposition	20	b. Place of cemeter)	Disposition (N., crematory of	ame of other plac	ce)	Date	20c. L	ocation - City	or Town, State
Page	nent of h ant: If ite ary or of		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Gi	rantsv	ille C	emete	ry July	7,2007	G	rantsv	ille, MD
m = 1	Department of Important: If it any injury or once.		21. Signature of Funeral Service License	ee)		22. Name	and Addres	ss of Facility eral Hom	es, P.A			
m =	20 = 20		Nam Ru	mace		179 M	iller	Street.	Grants	wi11	e, MD	21536 Approximate
			23a. Part1. Enter the disease, or complications, or head failure. List only on	cations that caused the decause on each line.	death. Do n	ot enter the m	ode of dyin	ig, such as cardia	or respiratory	arrest,		Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)		nced		emen	Ma	End	stag	۰	6 months
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120	装	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	tsaquence o	ty:						
uted	dansit	Examiner	that initiated events									
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6876 tificate be	hysici he bu	ical	d									
I Records, P.O. Box 68760, The law requires that the death certificate be executed	been signed by the attending physici should be detached for use as the bu	Physician/Medica	IF FEMALE:	On If was autooms of or	o an an au				Billion -		001.01.6	1.0
Box	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pr 1☐Live birth 2☐ 4☐Pregnant at time	Fetal death	3 ☐Ectopic 5 ☐ Other (/			23d. Date of o Month	Day Year
i g	the	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unknown	or death	2 Other (specify/					
d that	ed by detac	h h	Part II. Other significant conditions con	ntributing to death but no	t resulting in	the underlying	cause giv	en in Part I.	23e. Dio	tobacco	use contribute	to the cause of death?
ds	sign Id be	d by							10	Yes 2	2	Probably 4 Unknow
Records, he law requires t	shou	Completed							24a. Wa		24b. Were	autopsy findings available
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	tificat tor, p		25. Was case referred to medical					26. Place of De				55 24.5
or Vita Physiclan:	is cer direc	To Be	examiner?	lospital: 1 ☐ Inpatient	2 ER/Out	patient 3 🗆 I	DOA Oth	er: 4 Nursing I	Home 5□Re	sidence	6 ☐Other (S	Specify)
0 4	After this certificate has funeral director, page 2	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea		ime of njury	28c. Inju	y at k?	28d. Describ	e how inj	ury occurred	
Vision	or: Af	atio	2 Accident investigation			М		Yes 2 □ No				
Division or	ter de irect n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, fai pec <i>ify)</i>	m, street, fact	ory, office			(Street a own, Sta		Rural Route Number,
	urs af		Continue Dhy	nicion. To the best of m	, knowlodao	dooth occurr	ad at the ti	mo data and plac	e and due to th	o causal	e) and manna	r ae etated
Hospital	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 X Certifying Physical Check only one) edical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	mination an	, death occurred/or investigati	ion, in my	opinion, death occ	urred at the tim	e, date a	nd place, and	due to the cause(s)
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To	- ≯ ⊨ ర		workship	Elin MO)		井口	5537	5	Ji	ulu 5	2007
,			30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, Print)	71 5	220	-			1000
		3	Wonsock Shi	n, MO	18 Ta	rn Tes	rac	e Fro	stou	va	MD.	,2007
\$	≗ St	ate	31. Date filed (Month, Day, Year)	32. Redistrar's	Signature					1		
	Regist	rar	JUL - 6 2	4001	a de	A SOM	The B					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 0605 Jr. 2007 Claude McGee July 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not igstitution, give street and number) (NICOMERO REGIONAL MEDICAL SATTER PALISBURY 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days 8/17/1938 1**X** M 2 □ F North Carolina 68 246-56-3285 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 X No Maryland Wicomico Parsonsburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21849 33152 Shavox Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 K No Specify Specify Completed by 3 Widowed 4 Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barr International Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winnie Loveaide Ledford McGee Claude ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 33152 Shavox Rd., Parsonsburg, Maryland 21849 Dorothea McGee/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place)
Meadowridge Memorial 1 Burial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 7/9/2007 Elkridge, Maryland Park 21. Signature of Funeral Service License 2 Name and Address of Easility 1 Home PA 501 Snow Hill Rd. Salisbury, Maryland 21804 Rene 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) P Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1. Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician; The law requires that the death certificate be executed burial-trar attending physician Division or Vital Records, P.O. Box 68760 the the signed by t director, this funeral After t within 24 hours after death To the Funeral Director: filled in by the

Hospital

Physician

/Medical

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at

permit. Page Department or Important: If any Injury or

Physician /Medical

Examiner

Maryland 21215-0036

3altimore,

-56-3285

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

> s of person who completed cause of death (Item 23a) (Type, Print) 100

32. Registrar's Signature

State

Medical

30. Name and addre

(Month, Day,

JUL 06

2007

31. Date filed

Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	iryiaria / L		ificate of l		nemarry	Reg. N	/ 5 1 1 1	234.05
٠	C		1. Decedent's Name (First, Middle, L	ast)					2. Date of De		ay Year	3. Time of Death
	Physici /Medic		Liliane Luc	y Martinos -	Hentges				June 2	29, 2	2007	5:24 ам
¥.	Examin	4	4a. Facility Name (If not institution, g	ve street and number)			4b. City, Town, or	Location of Death		4	c. County of Deat	th
		yas i	Washington Adven	tist Hospital				a Park			Montgo	
	Funeral Director		5. Social Security Number 6. 212-76-4007	Sex 7. Age 1 M 2 K F	(In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di May 17	ay, Yea		thplace (State or Foreign ountry) embourg
13	D D		Usual Residence of Decedent									
	irylan show	_	10a. State 10b. County		10c. City, Tow	n or Loca	ation					10d. Inside City Limits
	e Ma Sa-f s	Director	Maryland Montgo	nery				r Spring				1 ☐ Yes 2 K No
	or 24	Dire	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	ountry?
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	er de	nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	0	1 [□Yes 2⊠No	Specify:			Specify:	White
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Maryland	2 sh n and ris m		19a. Informant's Name/Relationship		1	_	•	and Number or Ru				
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jor	iges It of I		1⊠Burial 2☐Cremation 3		cemete	ry, crema	atory or other plac	ce)			•	
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Baltimore,	permi Depar Impor any Ir		21. Signature of Fun ral evice lice	Lenten	~	Hin	Name and Addres nes-Rinaldi 300 New Ham	Funeral H	ome, Inc. nue, Silv	ver S	Spring, Man	yland 20904
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Ä	The lav	mo								opsy formed 2 🕰	? death?	completion of cause of 2 ☐ No
ita		BeC	25. Was case referred to	1				26. Place of Dea				
<u> </u>	ys di is	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2□ER/O	utpatient	3□ DOA Oth	er: 4 ☐ Nursing H	ome 5□Res	sidence	6 □Other (Spe	ecify)
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Division	or At after d Direct in by	Certification:	4 ☐ Homicide determine		iry - At home, fa c. (Specify)	arm, stre	et, factory, office		City or To	(Street own, St	and Number or H ate)	ural Route Number,
	Hospital 24 hours a Funeral stely filled		29a, Certifier 1 Certifying	Physician: To the best of	of my knowledge	e. death	occurred at the tir	ne date and place	and due to the	e cause	e(s) and manner a	s stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		aminer: On the basis of and manner sta	examination ar							
	To th Within To th	Me	29b. Signature and title of certifier			<u>-</u> -	29c. Licens	e number		29d. l	Date signed (Mon	th, Day, Year)
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	φ		30. Name and address of person wh						1	_ U	1~11	7
_			Nasreen Mustafa Ka	ngo, M.D., 761	0 Carrol	1 Ave	nue, Suite	205, Takon	na Park,	Mary	land 20912	
	Sta		31. Date filed (Month, Day, Year)	32 egistra	ar's Signature	-	16					
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		-	For State Registrar	State of Mar		artment of H rtificate of I		•	giene Reg. No.	9-7	991.0:
			Decedent's Name (First, Middle, Last)	")				2. Date of De	ath	Voor	3. Time of Death
я.	Physicia /Medic		Anne Marie Mata	n				Month June	Day 30. 200	Year 7	1:59 P M
	Examin	-57	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	7 0.110	4c. County		
		G.	4218 Glenridge St	reet		Kens	ington		Montg	omer	37
-76-	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th T	9. Birthp Coun	lace (State or Foreign
ш	Director		221-46-3873	□M 2½ F	95 Yrs.	,				Penne	sylvania
	pu ,		Usual Residence of Decedent 10a. State 10b. County		0c. City, Town or Lo	cation					0d. Inside City Limits
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	ns 23	era	4218 Glenridge 11. Marital Status	12. Was Decedent Ev	er in U.S. 13.1	20895 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No	USA 14. Race		an Indian,
	r iten	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 1 No				Rićan, etc.)		k, White,	
93	ursa al',o Exam	by	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify.	Whit	te
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of Bu	siness/Ind	dustry
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	filed wi Hygien other th	ပ္ပ	12		Hor	memaker			Own H		
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yla	2 should be and Mental is marked craumatic ev	မ	Philip E. Caulfi						th Corre		
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (T			ng Address (Street					ŕ
	and sealth m 27	- 1	Anne Matan Easby- 20a. Method of Disposition	Smith/Daugl	nter 4218	Glenrid	ge Street	Kens	ington, I	MD 50	0895
Ö	Pages 1 and 2 should be filed within 72 hours after death with the Marylan hent of Health and Mental Hyglene, nt; If Item 27 is marked other than "natural", or items 23a or 28a-f show int; If Item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ I		cemetery, crei	matory or other plac	<i>(e)</i>	_	ZOC. LOCATION -	City or To	Jwit, State
Ħ,	t. Pag tment tant; I	ΙV	4 □ Donation 5 □ Other (Specify		St. Antho	ony's Chu Mame and Addre	rch July 200	7 3,	Emmitsb	ırg,	Maryland
Baltimore,	permit. Page Department Important; If any injury of once.		21. Signature of Funeral Service Licens		+ I	Trancis J	. Collins	Funera	al Home	Inc.	
			220 Port1 Enter the disease or come	alibations that caused the		00 Unive	rsity Bly	d. W.	Silver S	Sprin	pproximate
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Вох	death certif e attending d for use as	A L	23b. was decedent pregnant	23c. If yes, outcome pf 1 ☐ Live birth 2		□Ectopic pregnanc	,			e of delive	
	dea'	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at ti 9□Unknown		Other (specify)			Mo	ntn	Day Year
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brd	w requires to been signer should be o								Yes ZIXINO	3 Prot	bably 4 ☐ Unknown
Ö	2 38 2	ple						24a. Was	psy	prior to co	opsy findings available impletion of cause of
H =	Th ate pag	Completed						perf 1□ Yes		death? I □ Yes	2 No
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7	Physi r this o	မ	X res 2□ NO		t 2 ER/Outpatie		4 ⊔ Nursing H		idence 6 Oth		fy)
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Sic	p st ge	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		y - At home, farm, st		Yes 2 No	29f Location	(Street and Numb	or or Bus	al Poute Number
Division	or Atten after deatl Director: in by the	ertification:	4 Homicide determined	building, etc.	(Specify)	reet, lactory, office		City or To	own, State)	er or nure	ar noute ivariber,
	Hospital 24 hours a Funeral tely filled	O	29a, Certifier 1 A Certifying Ph	ysician: To the best of	my knowledge, dea	th occurred at the ti	me, date and place	and due to the	e cause(s) and ma	anner as s	stated.
	24 hc 24 hc Fun etely	Medical		niner: On the basis of and manner state	examination and/or in						
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	Me	29b. Signature and title of certifier	100	^ 1	29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
	C>F0		1 1 1	1 (and	LO I MIZ	_ D4	13699		July 3,	200	7
١	19		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	, Print)		<u>_</u>			
			J. Patrick Caulfi	ield, M.) 10215 F	ernwood I	Road, Bet	hesda,	MD 20815	5	
		ate	31. Date filed (Month, Day, Year)	32. P gistrar	's Signature	land a				_	
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Baltimore, Maryland 21215-0036		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Donestmant of Logith and Mortel Livings.	yland	E
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	ire	้นท
any injury or other traumatic event, the Medical Examiner must be notified at	cto	er
once.	or	aL

Physicia /Medic Examin

Physician /Medical Examiner Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sta

	For State Registrar			Cer	tificate of L	Death	2. Date of Dea	leg. No.	007	3. Time of Death
۱	Decedent's Name (First, Middle, Last)						Month	Day	Year	6:50 am
7	Justine L. Mills					La company of David	June	29	2007	
	4a. Facility Name (If not institution, give stre	et and number)			4b. City, Town, or	Location of Death	n		ounty of Death	
	Laurel Regional Hospi					Laurel			Prince Ge	
-	5. Social Security Number 6. Sex	2 🔀 F	(In yrs. last i		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign ntry)
	577-62-0344	2 23 1	80	Yrs.			July 20,	1926	New	Jersey
	Usual Residence of Decedent		40- Ob. T.							and traile on their
	10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
2	Maryland Howard]	Laurel					1 □Yes 2XNo
	10e. Street and Number				10f. Zip Code		1	10g. Citize	en of What Cou	ntry?
,	9439 Madison Avenue					20723			U.S.A.	
5	140	Was Decedent B	verintls	13 V	Vas Decedent of Hi		becify Yes or No-	14	4. Race - Ameri	can Indian.
5	11. Marital Status 1 Never Married 2 Married	Armed Forces?		1.01	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puèr	to Rican, etc.)		Black, White,	etc.
	3 ☑ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1	☐Yes 2█ No	Specify:		5	Specify: B1	ack
3			1 44			41		4.0h 161	1 - (D i (i -	
completed by raileral billector	15. Decedent's Educat (Specify only highest grade c	on ompleted)	16	(Give	lent's Usual Occupa kind of work done of	uring most of wor	rking	IOD. KING	d of Business/Ir	iduStry
-	Elementary/Secondary (0-12)	College (1-4or 5	+)	iire. L	OO NOT use retired,					
5		4			Statisti				Governme	nt
í	17. Father's Name (First, Middle, Last)					18. Mother's Nar	me (First, Middle,	Maiden S	iurname)	
	Elmus Graham Baas					Justin	e A. Crock	er		
	19a. Informant's Name/Relationship (Type.	Print)	1	9b. Mailin	g Address (Street a	and Number or Ri	ural Route Numbe	r, City or	Town, State. Zi	p Code)
	Gary Mills - Son	,	- 1		ntford Cour					,
					sition (Name of	, DIIVEL	Date Date		ation - City or T	own State
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Ren	oval from State	ceme	tery, cren	natory or other place	9)	Date	200. L00	ation - City of 1	own, State
	4 □ Donation 5 □ Other (Specify)		Fort I	incol	n Crematory	7/10	/2007	Brent	wood, Ma	ryland
1	21. Signature of Funeral Service Licensee	0 ,	*		. Name and Addres		T			
J	(manda)	Kuden	ra.	1 1	ines-Rinald: 1800 New Ha	i Funerai moshire Av	renue, Inc.	er Sp	ring. Mar	yland 20904
	23a. Part1. Enter the disease, or complica	ions that caused	the death. D	_		-	· · · · · · · · · · · · · · · · · · ·			Approximate
	shock, or heart failure. List only one	cause on each lin	10.		-					Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	Aspira	ation Pn	eumon:	ia					···-
	resulting in death)	Due to (or as	a consequenc	e of):						
	Commentally list conditions	End St	age Alz	heime	r's Disease					
0	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or ea:	a consequence	н обр						
	Cause (Disease or injury that initiated events									
7	resulting in death) Last	Due to (or as	a consequenc	e of):						
5										
cuical Evallille	d									
	IF FEMALE:	If you and a second	nf nv							
<u>=</u>	23b. Was decedent pregnant	If yes, outcome 1□Live birth		ath 3□	Ectopic pregnancy			23	3d. Date of delive Month	ery Day Year
2	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at 9□Unknown			Other (specify)				MOTILIT	Day Teal
	9 ☐ Unknown	2 OHKHOWII								
L	Part II. Other significant conditions contri	buting to death be	ut not resulting	g in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
completed by rugalciallying							1 🗆 Y	′es 2ℤ	No 3 □ Pro	babiy 4 🗆 Unknown
							TAKE TO	19		v. 11.1
1							24a. Was a autop	sy	prior to co	opsy findings available ompletion of cause of
5							perfoi	rmed?	death?	2 No
ر	25. Was case referred to medical					26. Place of De	ath (Check only or			
)	examiner? 1 ☐ Yes 2[X]No	pital:	nt 2□FR/	Outpatien	t 3 DOA Othe	er: 4 🗆 Nursing F	Home 5 ☐ Resid	lence 6	Other (Spec	ifu)
j	27. Manner of Death	28a. Date of Inju	ry 281	o. Time of	28c. Injun	/ at	28d. Describe h			"7/
5	1 ☑ Natural 5 ☐ Pending	(Month, Day		Injury	Work	? Yes 2∐No		,,		
5	2 Accident investigation 3 Suicide 6 Could not be	00 - P! 11 1		4		169 ₹∏140	001			
	4 Homicide determined	28e. Place of injudence of inju	ury - At nome, c. <i>(Sp</i> ec <i>ify)</i>	rarm, str	eet, factory, office		28f. Location (S City or Tow	reet and n, State)	Number or Rui	ral Route Number,
medical Celunication, 10 De	29a. Certifier Certifying Physic									
2	(Check only 2 Medical Examine one)	r: On the basis of and manner sta		and/or in	vestigation, in my o	pinion, death occ	urred at the time,	date and	piace, and due	to the cause(s)
	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Month	, Day, Year)
					D m n	645		OF	1201	-
	14 00 11 2		11				Sm -7			
	K. Slical	ا نما	MD		Doc	649	21	00	2910	
	30. Name and address of person who com			a) (Type,		649	31		12910	0]
	30. Name and address of person who com Sricatha Kanumuru, M.I	oleted cause of d	eath (Item 23		Print)		,		12910	0]
	Sricatha Kanumuru, M.I 31. Date filed (Month, Day, Year)	oleted cause of d	eath (Item 23	Road	Print)		,		[29](01
	Sricatha Kanumuru, M.I	oleted cause of d	eath (Item 23) an Dusen	Road	Print)		,		[29](<u> </u>

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 20b, perFh, G869. 7/31/07 TT Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician Month Year рΜ Alfred John Maguire 29, 2007 7:50 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3004 Windy Knoll Court Montgomery Rockville If Under 1 Year
Months Days If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1₩ 2□F Months Director 254-30-7895 84 Sept. 16, 1922 Georgia Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3004 Windy Knoll Court 20850 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Unknown Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ^oL Alfred John Maguire Sr. Josephine Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred John Maguire III 3004 Windy Knoll Court, Rockville, Maryland 20850 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 7/12/2007 1 ☐ Burial 2 Tremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Per the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate asse (Final disease or condition resulting in death) Physician years Dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed Course (Disease or injul that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 ☑Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Maquia JR., 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 🙀 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours af 1 decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) D20148 July 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dolinsky M.D. 911 Russell Ave. Gaithersbug, Maryland 31. Date filed (Month, Day, Year) **B**gistrar's Signature State JUL 0 6 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician MC EIROY 0660 PM Helen 0 7007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Rehab & Nursing Burtonsville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 97 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplece (State or Foreign Rhode Island **Funeral** 037-16-1696 1 ☐ M 2 🔀 F 1/27/1997/1909 Director Usual Residence of Decedent deeth with the Maryland permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiane. Importent: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show way injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits MD Burtonsville Montgomery 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20866 USA 3415 Greencastle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Completed by 3 →Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Co. Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rillah M. LaFountain Fred Joseph Hart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6207 Kaybro Street Laurel, Md. 20707 19a. Informant's Name/Relationship (Type, Print) Rosemary Remsburg/Daughter 6207 Kaybro Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemelery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem 7/03/2007 Beltsville, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Livens PHYLIP Address FINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Althorosc Cardiovascular Physician lentu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit pue Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physicien Physician/Medical USB as 1 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) After this certificate has been signed by the if funeral director, page 2 should be detached 1 ☐ Yes 2 D No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tension 1 Yes 2 AND 3 Probably 4 Unknown Dementa 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 1 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide efter To the Hospital o within 24 hours of To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10605333 7-2-07 Dorothy M. Seay, M.D. 30. Name and address of person who completed days of death (Item 23a) (Type, Print) montlex Smith Suite 200 Avenue 2835 31. Date filed (Month, Day, Year) gistrar's Signature State 2007 Registrar

		•	for State State Registrar	of Maryland		irtment of F tificate of		-	giene Reg. No		
		7	Decedent's Name (First, Middle, Last)					2. Date of De	ath	2017	3Time of Death
	Physicia /Medic		Carmen Betty Mills					Month July	2, Day	y Year 1007	6:50 A. M
î	Examin	_	4a. Facility Name (If not institution, give street and	number)		4b. City, Town, o	Location of Death			County of Death	
	- 145 - 176 - 1		Buckingham's Choice			Adamsto				Frederio	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M 2 M	7. Age (In yrs. las	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Decemb	y, Year)	I COL	place (State or Foreign intry) PA
1	ਰ		Usual Residence of Decedent							. , - , - ,	
	arylar show	ř	10a, State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2X No
	the M 28a-f lotifile	Director	MD Frederick 10e. Street and Number	Ada	amstor	n 10f. Zip Code			10a Cit	izen of What Cou	
	with Ba or	۵	3200 Baker Circle #A-	114		21710	1				muy?
	ms 2; mus	Funeral	11 Marital Status 12. Was	Decedent Ever in U.S.	13. V		ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No		S.A. 14. Race - Amer	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Yes	d Forces? ′es 2⊠ No , Give or Dates:		Yes, specify Cub	Specify:	Hican, etc.)		Black, White Specify: W	, etc. hite
15-0036	n 72 ho "natur edical I	Completed	15. Decedent's Education (Specify only highest grade complete	ted)	(Give I	ent's Usual Occup kind of work done OO NOT use retired	durina most of worl	king	16b. K	ind of Business/l	ndustry
12.12	withi	mo	Elementary/Secondary (0-12) College	ge (1-4or 5+)		maker	-/		Owr	n Home	
٥	be filed Ital Hygi of other event, i	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden	Surname)	
<u>Iar</u>	should b ind Ments marked umatic e	2	Albert Ward Gladfelter				Mary Ed				
Jar	2 shc n and Is ma		19a. Informant's Name/Relationship (Type. Print)	1			and Number or Ru t., North				ip Code)
e,	1 and Health em 27 ther tr		Mrs. Diane M. Wright/D			-		Date		ocation - City or	Town State
Baltimore, Maryland 2	Pages nent of I		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal f	om state		sition (Name of natory or other place 1n Crem.	1			ntwood,	
ᆲ	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lifensee	A 1			ss of Facility Si				
ñ	Deg any		Dei Sym Hash-	truely/							Rockville,MD
A			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the death. on each line.	Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) Ren	al Cancer							Onset and Death
	/Medical Examiner		Dur	e to (or as a conseque	nce of):						
b		ē	Sequentially list conditions, if any, leading to immediate b.	e to (or as a conseque	nce of):						
	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events c.								
Ö,	ificate be executed y physician and ss the burial-transit	EX		to (or as a conseque	nce of):						
98760	cate b physic the b	edical	d								
_		/Me	IF FEMALE: 23c. If yes 23c. Was decedent pregnant	, outcome pf pregnanc	:y	_				23d. Date of deli	von.
Box	0 0 0	Physician/M	in the past 12 months?	ive birth 2□Fetal d regnant at time of dea	eath 3	Ectopic pregnanc Other <i>(specify)</i> _	/ 			Month	Day Year
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	The law requires that the de tte has been signed by the a kage 2 should be detached f	ρ	Part II. Other significant conditions contributing Anemia	to death but not resulti	ng in the ur	iderlying cause giv	en in Part I.				the cause of death?
Š	requ	eted	1				74.74	10			obably 4 □Unknown
Vital Records,	sician: The law s certificate has l irector, page 2 s	Completed						24a. Was auto perfe		24b. Were au prior to c death?	topsy findings available ompletion of cause of
g			25. Was case referred to medical				96 Place of Dec	1□ Yes	X √X No		2□No
	hysicia this cer	To Be	examiner?	1 ☐ Inpatient 2 ☐ EF	R/Outpatien	t 3 DOA Oth	er: 41/2 Nursing H			6 ☐Other (Spec	eify)
0	fer Ter		27. Manner of Death 1 XNatural 5 Pending (Date of Injury 2 Month, Day Year)	8b. Time of Injury	28c. Injui Woi		28d. Describe			,
<u>S</u>	tendi leath. tor: A the fu	catic	2 ☐ Accident investigation			M 1□	Yes 2 □ No				
Division or	after d	Certification:	determined 200.	Place of injury - At homouilding, etc. (Specify)	e, farm, stre	eet, tactory, office		28f. Location (City or To	Street ar wn, State	nd Number or Ru e)	ral Route Number,
	spita nours neral y fillec		29a. Certifier 1 Certifying Physician: To	the best of my knowle	edge, death	occurred at the ti	me, date and place	, and due to the	cause(s	and manner as	stated.
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edical	(Check only 2 Medical Examiner: On t	he basis of examinatio manner stated.	n and/or inv	vestigation, in my	opinion, death occu	rred at the time	, date an	d place, and due	to the cause(s)
	With To t	Ž	29b. Signature and title of certifier	•		29c. Licens	e number		29d. Da	ite signed (Month	, Day, Year)
	12		Waren MI			D0058	726		Ju1	y 3, 200	7
			30. Name and address of person who completed Yvette Warren, M.D., 3				0201111	MD 01	770		
	Sta	te	31. Date filed (Month, Day, Year)	32 egistrar's Signatui	re		CISATITE.	MD 21	1/3		
	Registr	ar	JUL 0 6 2007	man It	190	المالية					

State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	(Reg. No.	07	23411
Physician	1. Decedent's Name (First, Middle, Last)	Þ	,		2. Dete of Dea Month	ath Day	Year	3. Time of Deeth
/Medical	ROBERT		MARIC		06		007	07324
Examiner	4a Fecility Neme (If not institution, give si				Location of Death		y of Death	45016
	WASHINGTON A			TAKON If Under 24 Hr.	IA PARY	Moi		
Funeral Director	5. Social Security Number 6. Sex 15 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	M 2□ F 73	Yrs. Months Days	Hours Mir		, Yeer) 1933	9. Birthp Coun	place (State or Foreign ptry) MD
/land	10a. State 10b. County	10c. Cit	y, Town or Location				1	0d. Inside City Limits
Man Fret	MD Prince Geo	rge	Adelphi					1 ves 2 □ No
r 284	10e. Street end Number	/1 gc	10f. Zip Code			10g. Citizen of	What Coun	itry?
3a o	2702 Curry Dr.		20783			USA		
offer death with the Ma wr flems 23a or 28a-f s winer must be notified Funeral Director		2. Was Decedent Ever in U,	S. 13. Was Decedent of	Hispanic Origin? (Specify Yes or No	14. Ra	ce - Americ	
	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cut 1 ☐ Yes 2√2 No		no Hican, etc.)	Specia	ack, White, of fy: Whi	
ed within 72 hours ef ygjene. er than "natural", or rt, the Madical Exami Completed by F	15. Decedent's Educa	ation	16e. Decedent's Usual Occu	pation		16b. Kind of E		
hin 7	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of wo	onking			
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d 2 should be filed with the and Mental Hygiene. 7 Is marked other than traumatic event, the To Be Comp	17. Father's Neme (First, Middle, Last)			18. Mother's Na	ame (First, Middle,	Maiden Suma	me)	
sould by I Menta	Author R. Marion			Grace V	. Dove			
2 should be shou	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Address (Stree	t and Number or F	iurel Route Numbe	er, City or Town	, State, Zip	Code)
1 end 2 Health e em 27 ls ther tra	Constance Stringfel	low / Sister	5910 85th Ave	. New Car	rrollton.	MD 20	0784	
es 1 e of Hei	20a. Method of Disposition	20b. P	lace of Disposition (Name of emetery, crematory or other pla		Date	20c. Location		wn, State
Memit. Pages 1 er Appertment of Hea Apportant: If Item iny Injury or other Ance.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	dar Hill Cemete		7/6/2007	C		(D)
emit. Pages 1 end Depertment of Health Important: if Item 27 any Injury or other ti ance.	21. Signature of Funeral Service Licenses		22. Name and Addre	ess of Facility	7/6/2007	Sultia	ind, M	ID
permit. Depertr Imports any Inji pnce.	Mary Ledgman		4111 Penns	ylvania .	Ave. Suit	land,	MD 20	ie 746
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deeth cause on each line.	n. Do not enter the mode of dyi	ng, such as cardia	ac or respiratory ar	rest,	1	Approximate Interval Between
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Medical Examiner	Immediate Cause (Final disease or condition	GASTRO1	NRSTINA	- BL	EEDI	VG-	+	
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entificete be executed ling physician and is es the burial-transit	Sequentially list conditions,	Due to (or	r as a consequence of):					
ifficete be exing physician est the burial.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury							
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th ce tending or use	- 6.							
dea he at hed fc	Part II. Other significant conditions contr	ibuting to death but not resu	ulting in the underlying cause gi	ven in Part I.	23b. Did t	obacco use co	ntribute to	the ceuse of death?
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit Completed by Physician/Medical Examir					1 🗆 1	res 2□ No	3 🗌 Prot	pably 4 yoknown
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The law requireste has been spage 2 should							con	mpletion of cause death?
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E E = -	27. Manner of Deeth	28e. Date of Injury	28b. Time of 28c. Inju		28d. Describe h			
or Attending Refer death. Director: After 3 in by the funer ertification:	1 Natural 5 Pending 2 Accident investigation	(Month, Dey Year)		rk? Yes 2.∐.No				
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efter Direction by	4 Homicide	building, efc. (Specify)		City or Tow	m, State)		
Hospit 24 hou Funer stely fill	29a. Certifier (Check only one)	cian: To the best of my know er: On the besis of examinet and manner steted.	vledge, death occurred at the ti ion and/or investigation, in my o	me, date end plac opinion, death occ	e, end due to the durred at the time, d	ause(s) and m date and place,	anner as sta	ated. the cause(s)
within To the comple	29b. Signature and title of certifier	and marrier stoted.	29c. Licens	se number		29d. Date signe	ed (Month, I	Dav. Year)
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		un.	000	60319	1	06	,01,	2007
(2)	30. Name end address of person who com DARCE 21. Data filed (Month Pay York)	pleted cause of death (Item	23e) (Type, Print)	and Da	Cutan.	7 P4	·V	(/ AA D
	21 Date flood (Marth Day Year)	TAMMER	C/JUU FICE	4ra yr.	Juleu	IL NO	2010	ie idly
State Registrar	JUL 0 6 2007	32. Registrer's Signat						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	Ce.	rtificate of		F	Reg. No.	17	231.12
ě	Physici /Medic		1. Decedent's Name (First, Middle, Last) Primo Loren	zo Moody				2. Date of Dea Month 06	Day	Year 007	3. Time of Death 12:20 P M
335	Examir	- 4	4a. Facility Name (If not institution, give s Calvert Memorial				r Location of Deat Federick	h	4c. County		
h.,	Funeral Director		5. Social Security Number 6. Sex 579-84-5990		(In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days		(Month, Day	1959	9. Birthp Coun	lace (State or Foreign try) DC
	Maryland f show ied at	ior	Usual Residence of Decedent 10a. State 10b. County DC None		10c. City, Town or Lo					1	0d. Inside City Limits 1
	h with the	al Director	10e. Street and Number 1429 Third Stree	t S.W.		10f. Zip Code	0024		10g. Citizen of V	Vhat Cour	itry?
036	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	fispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		e - Americ k, White, Blac	etc.
21215-0036	within 72 ho lene. than "natul the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5-	-) (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wor d)	rking	16b. Kind of Bu		ndustry
Maryland 2	uld be filed valued Hygier rked other tic event, the	To Be Co	17. Father's Name (First, Middle, Last) Rollins B. Mood	у		<u> </u>		me (First, Middle, A. (unkn	Maiden Surnam	ie)	nausery
	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked, any injury or other traumatic evonce.		19a. Informant's Name/Relationship (Type Valencia Moody /		1429	ng Address (Street Third St	reet SW;		ton, DC	2002	4
Baltimore,	it. Pages 1 Intment of H Intant: if ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	-1		matory or other place Le Cremat 2. Name and Addre	ory 07/0	02/2007		ale,	MD
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68760,	rificate be executed was physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):	~					
P.O. Box 687	The law requires that the death certificate te has been signed by the attending physings 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome p 1□Live birth : 4□Pregnant at 9□Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc	y		23d. Dat	e of delive	ery Day Year
ords, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions con Seizwe disords		t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to		ribute to th 3 Prob	ne cause of death?
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Division or Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1	28a. Date of Injur (Month, Day) 28e. Place of Injur	Year) Injury ry - At home, farm, st	M 1	ryat rk? Yes 2 ☐ No		now injury occurr		il Route Number,
á	Hospita or A		29a. Certifier 1 CertifyIng Phys	building, etc ician: To the best of ier: On the basis of	(Specify) f my knowledge, deal examination and/or in	h occurred at the ti	me, date and place	City or Tow	n, State) cause(s) and ma	inner as s	tated.
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	V		30. Name and ax ress of person who ∞	moleted cause of do	ath (Item 23a) (Tuno		0390		06/25	/200	07
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State Registrar

ADEED JABER 100 HOSPITAL RO., PRINCE FREDERICK MD 20678

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LAURA L. JENNINGS, 3001 HOSPITAL DRIVE; CHEVERLY, MD 20785 State 31. Date filled (Month, Play, Year) 2007 32 Registrer's Signature		pital ours a orai filled		20g Cortifier 113 Contibute Dhysician To the hear	a a and an and a	dan dan baran da				45	
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		Stat Registra	е	31. Date filed (Month Play, 2007 2007 3 Pegis	rer's Signal e	good					

DHMH 16 Rev 6/95

ien Quang	Nguy	1 R	- For State	ate of Maryla		rtment of tificate of		and	Menta		Re	g. No.	ָּטָט '	7 2341
	sicia	n/	Decedent's Name (First, Midd								Date of Deat Month July 2, 200	Day Yea		3. Time of Death 2210 hrs
ledical Ex	amm		Hien Qi 4a. Facility Name (if not institution MONTGOMETS/AII)	nang Nguyen n, give street and nu neral Hos	mber) pital	4	b. City, Tow Olney	n, or Lo	ocation of		4c. County of Dea Montgomery			
Fune Direc			5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1	Year Days	If Under	24Hrs. 8 Min.	8. Date of Bir	th (MM/DD/YYYY	9. Birth	place (State or
	28a-f show any	***	Usual Residence of Decedent 10a. State 10b. County Maryland Monta	gomery		Town or Location			r Spri	ng		1 Od. Inside City Limits 1 Yes 2 No		
after death with the Maryland	ms 23a or 28a-f sho be notified at once.	Dir.	10e. Street and Number 808 Heroi 11. Mantal Status		20	0901 anic Origir	n? (Spec	ify Yes or No						
after death	1 X Never Married 2 Married 1 Yes 2 X No										Specify:		Asian	
215-0036 be filed within 72 hours ntal Hygiene.	other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)		ost of workin	g life. I	DO NOT u	se retired		16b. Kind of Bu	nputer			
21215-0036 build be filed within 7 Mental Hygiene.	To Sompteet Trogst To Sompteet Trogst To Sompteet Trogst To Father's Name (First, Middle, Last) Peter Hach Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and									guyet	T. Ngu			Zin Code)
MD rd 2 sho	it: If item 27 is marked other traumatic event,		Nga T. Nguyen	- Sister			ther Ro	ock :	Place,	Rock		Maryland 20c. Location	20850	
Baltimore, permit. Pages 1 an Department of Hea	portant: If ury or other	-	1 x Burial 2 Crematio 4 Donation 5 Other S 21 Signature of Funeral Service	pecify:	IOIII State	te of Hea	ven Cen	dress	of Facility	7/7/	2007 me, Inc		Spring	, Maryland
Physic Med	cian lical		23a. Part I. Enter the disease, o failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause.	a. Atheroscle Due to (or as b. Due to (or as	caused the death	n. Do not enter the vascular Discord):	ne mode of	Ham:	pshire	Aven	espiratory arr	ver Sprin est, shock, or he	g, Mar art	Pyland 20904 Approximate Interval Between Onset and Death
b,	ician and urial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o	of):								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.	attending phys for use as the b	siciar	UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Un	the 23c. Tyes	nant at time of de	gnancy 2 Fe	MoCo stal death ther (Specif	3 [Ectopic	pregnand	ру	23d. Date of Month		ay Y ear
s, P.O. I	d be detached	ed by Phy	Part II. Other significant cond	itions contributing	to death but not r	resulting in the u	underlying c	ause gi	ven in Par	t I.	1Ye	s 2 No 3	Prob	he cause of death? ably 4 V Unknown opsy findings available
Records The law req	icate has been s page 2 should 1	Completed									1 ✓ Yes	psy ormed?		ompletion of cause of
ital sician:	this certificate I director, page	BB	25. Was case referred to medic examiner?	Al Hospital: 1	Inpatient 2	ER/Outpatient		1	of Death (Home 5	Residence 6	Other	
of V	After th	n: To	1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Per	28a. Dat (Mon	e of Injury th, Day,Year)	28b. Time of I	Injury 28		y at Work?		8d. Describe	how injury occu	red	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that twithin 24 hours after death.	25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28c. Place of Death (Check only one) 28d. Describe how injury of Investigation as Suicide 28d. Describe how injury of Investigation as Suicide 28d. Place of Injury - At home, farm, street, factory, office building, etc. 28d. Location (Street and Nor Town, State) 28d. Date of Injury - At home, farm, street, factory, office building, etc. 28d. Location (Street and Nor Town, State) 28d. Date of Injury - At home, farm, street, factory, office building, etc. 28d. Location (Street and Nor Town, State) 28d. Date of Injury - At home, farm, street, factory, office building, etc. 28d. Location (Street and Nor Town, State)											per or Rui	ral Route Number, City	
o the Hospii ithin 24 hour	o the Funer	Medical Ce	29a. Certifier	Physician: To the be aminer:On the basis and manner	of examination	dge, death occur and/or investiga	rred at the ti	me, da	te and pla	ce, and d	lue to the cau	and place, and	due to the	e cause(s)
5		Me	29b. Signature and title of centil	M.	16			O.C.N	e number M.E.			July 3, 20		nth, Day, Year)
			30. Name and address of person Jack Titus MD. De	n who completed ca puty Chief Med			nn Street	, Balt	imore, P	MD 212	201			
	Si	ate	31. Date filed (Month, Day, Yea	2007 32	egistrar's Signat	ture la	all D							

		•	For State Registrar	State of N	Maryland / Depa Cea	artment of H			giene Reg. No: UU	2345
	Physici		Decedent's Name (First, Middle, La EARLE	H. 0'D	ELL			2. Date of Dea Month JUNE	29 2007	3. Time of Death 1:00 P M
	/Medic Examir	1.0	4a. Facility Name (If not institution, gir		r)		Location of Deat	h	4c. County of D	GEORGE 'S
	Funeral Director		5. Social Security Number 6. 084-18-0710		Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		2 (1923 N	Birthplace (State or Foreign VEW YORK
	Maryland I-f show	tor	Usual Residence of Decedent	EORGE'S	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23s or 28s	rai Director	10e. Street and Number 5204 DEVONPORT	COURT		10f. Zip Code 20769			10g. Citizen of Wha	
36	72 hours after death with the Maryland "natural", or Itame 23a or 28a-f show dical Examinat har collided at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Tyyes 2 If If Yes, Give Year or Dates	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. BLACK
21215-0036	d within 72 hou piene. Ir than "nature tre Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	rade completed) Coffege (1-40	r 5+) (Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo		16b. Kind of Busine	·
	be filed stal Hygi od other event, I	Be	17. Father's Name (First, Middle, Las EARLE H. O'DELI		s COR	RECTIONAL	18. Mother's Na		GOVERNME Maiden Sumame)	ENT
Maryland	12 sh h and 7 le m Iraum	To.	19a. Informant's Name/Relationship SHARON O'DELL/DA	(Type, Print)			and Number or R	ural Route Numbe	or, City or Town, Sta	
Baltimore,	of T		20a. Method of Disposition 1 2 Burial 2 Cremation 3 4 Donation 5 Other (Spec		(0)	osition (Name of matory or other place VETERANS	1	Date 7/5/2007	20c. Location - City OWINGSMI	y or Town, State
Balt	permit. Pag Department Important: I any injury o	1 8	21. Signature of Funeral Service Lice	1			OVER ROA	AD LANDO	ER, MARYLA	
	Physician /Medical	/	23a Fart1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	as a consequence of):	ter the mode or dyin	ng, such as cardia	c or respiratory ai	rrest,	Approximate interval Between Onset and Death
,0,	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or o	as a consequence of).	fact	line	J		
x 68760,	ertificate b ling physic e as the b	Medical	IF FEMALE:	d.	grove	ma	0			
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify) _	<i>'</i>		23d. Date o Month	rdelivery Day Year
α.	w requires that been signed b should be deta	by	Part If. Other significant conditions	contributing to death	but not resulting in the u	underlying cause giv	ren in Part I.			te to the cause of death?
of Vital Records,	m	Completed	Corebra	fin	fore	lion		24a. Was autor perfo 1 Yes	prio dea	e autopsy findings available r to completion of cause of th? Yes 2. No
	Attending Physician: Thir death. cdeath. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No 27. Manyer of Death 1 □ Natural 5 □ Pending 2 □ Accident investigati	28a. Date of fi	ntient 2 ER/Outpatie	of 28c. Injur	ner: 4 Nursing	1	one) dence 6 □Other (how injury occurred	(Specify)
Division	i Di ite	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of	fnjury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (City or Ton	Street and Number own, State)	or Rural Route Number,
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medical	(Check only 2 Medical Expone)	Physician: To the beaminer: On the basis and manner	st of my knowledge, dea s of examination and/or in stated.	th occurred at the time the ti	pinion, death occ	e, and due to the curred at the time,	cause(s) and mannedate and place, and 29d. Date signed (A	I due to the cause(s)
	o a sist of a	-	29b. Signature and title of certifier	me	>	D	3031	8	6/29	107
1	10/	ate	30. Name and address of person wh DEMETROIS J. 31. Date filed (Month, Day, Kear)	CATEVENIS			DRIVE C	EVERLY,	MARYLAND	20785
	Regist		31. Date filed (Month 2007)	Baren	o. opera					

Natausha Vernell Owens
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

07-04849 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1. For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day June 25, 2007 V. OWENS 2058 hrs NATAUSHA Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince George's Hospital Center Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex **Funeral** Months Days Min Hours Director 18 1986 Country) OHIO MAY М 2 XF 21 212-17-8761 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 28a-f show DISTRICT HEIGHTS PRINCE GEORGE'S MD notified at once with the Maryland Director 10g. Citizen of What Country 10e, Street and Number 10f. Zip Code U.S.A. 20747 6701 ANNTON DRIVE 23a Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S 11. Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 Never Married 2 Married BLACK 2 X No Yes 0. after f Yes. Give Year Yes 2 No specify. Specify. Widowed Divorced Examiner "natural" à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nort of Health and Mental Hygiene.
ant: If item 27 is marked other than "r or other traumatic event, the Medical E. PRIVATE Baltimore, MD 21215-0036 SALES ASSOCIATE 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ZEPORA JENNINGS KEVIN OWENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 ANNTON DRIVE DISTRICT HEIGHTS, MARYLAND 20747 ZEPORA JENNINGS/MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) 1 YBurial 2 Cremation 3 Removal from State CLINTON, MARYLAND RESURRECTION CEMETERY 7/5/2007 rtant: Donation 5 Other Specify permit. 22. Name and Address of Facility 21. Signature of Funeral Service Ligenses J. B. JENKINS FUNERAL HOME 20785 ROAD LANDOVER . MARYLAND Approximate Interval r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, Physician Between Onset and failure. List only one cau each line Medical Death a. Multiple Injuries mmediate Cause (Final dise se raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year Month Day Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Unknown the 23e. Did tobacco use contribute to the cause of death? signed by the detacher Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 ✓ Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 V Yes 28d. Describe how injury occurred After 1 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Jun 25, 2007 Pedestrian struck by auto 2002 hrs Natural Yes 2 V No Pending Director: 2 🗸 Accident Investigation in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Surrey Service Drive @ Parkland Drive, Forrestville, MD determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Day, Year) and title of certifier June 26, 2007 O.C.M.E. and address of person who con d cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month 0 6 2 32. Registrar's Signa State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_		a	mend 17 per B.C.	State of Maryland g870 8/23/07	KBICertificate of	Death	Reg. N	6 4 1	23417
	Physici		1. Decedent's Name (First, Middle, Last)	FEMALE	E POPE	2.	Date of Deeth Month D	ay Year	7-07
	/Medic Examin Funeral Director	er	 Social Security Number () Sex 	tospital Cente	sst birthday) If Under 1 Yea Months Days		-		
	D		Usuel Residence of Decedent 10a. State 10b. County MD PRINCE (Town or Location AFITOL HEIG				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the N 3a or 28a-	Funeral Director	10e. Street end Number	Prine.	10f. Zip Code	20743	10g. C	itizen of What C	Country?
020	s 1 and 2 should be filed within 72 hours aftar death with the Maryland if Health and Mentel Hygiena. If the 27 is marked other than "naturel; or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at	by Funera		12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes:	13. Was Decedent of if Yes, specify Cu 1 □ Yes 2 ☑ No.	Hispanic Origin? (Specify ban, Mexican, Puerto Ric o Specify:	y Yes or No- an, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, hite, etc.
21215-0020	within 72 hou liena. than "natura the Madical E	Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retir	e during most of working ed)	16b.	Kind of Busines	
	ould be filed Mentel Hygie arked other atic event, to	Be	17. Father's Neme (First, Middle, Last)		7.44	18. Mother's Name (F		n Sumame)	Pole
Maryland	2 should and Men is marked	2	Craig Clifford 1 19a. Informant's Name/Relationship (Type MOTHER)		19b. Mailing Address (Street	et and Number or Rural R	loute Number, City		
Baltimore, I	8 ° ≥ 5		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	1901 BROOKS ace of Disposition (Name of metery, crematory or other p	lace)	1	Location - Oity of HEVERL	or Town, State
Balti	permit. Pag Depertment Important: any injury once.		21. Signature of Funeral Service Licenses		3001 HISPITI	TRIVE	E GEORGE HEIERLY, M		CENTER 185
Box 68760,	The law requires that the deeth certificeta ba executed at the seen signed by the attending physician and base as should be detached for usa as the bunal-transit are as the bunal-transit and a second at the secon	an/Medicai Examiner	23a. Pert1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	es e consequence of):	ynlyone	espiratory arrest,		Approximate Interval Between Onset and Death
P.O. B	the deet by the att ached fo	Physician/M	Part II. Other significant conditions con	tributing to death but not resul	iting in the underlying cause (given in Part I.	23b. Did tobaco		te to the cause of death? Probably 4 Unknown
of Vital Records, F	v requires that the deeth cer been signed by the attendin should be detached for usa	þ	Presund seps	is			24a. Wes an aut performed?		b. Were autopsy findings available prior to completion of cause of death?
I Rec	The law ate hes t page 2 s	Completed	Genetic about	rulity / dysm	oplic factur	Ó.S.	1 M Yes	2 No	1 ☐ Yes 2 ☑ No
f Vita	rsician: The s cartificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 INO	ospital: 1 ☑ Inpatient 2 □ E	FR/Outpatient 3□ DOA C	26. Place of Death (Cother: 4 ☐ Nursing Home		6 □Other (S)	pecify)
Division of	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Diractor: After this cartificate he completaly filled in by the funeral director, page	Medicai Certification: T	27. Mann Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day Year)		☐ Yes 2 ☐ No	d. Describe how in		Rural Route Number,
DİX	tai or At rs after o rai Diraci led in by	Certif	4 ☐ Homicide determined	building, etc. (Specify)	me, farm, street, factory, offic	9 201	City or Town, Sta	ite)	Tigrat Tiosio Tigration
	n 24 hou n 24 hou ne Funer pletaly fil	edicai	29a. Certifier (Check only one)	ician: To the best of my know er: On the basis of examinate end manner stated.	rledge, death occurred et the on end/or investigation, in my	time, date and place, and opinion, death occurred	et the time, date a	nd place, and d	ue to the cause(s)
	Withi Com	Σ	29b. Signature and title of certifier Laura J-	ap, Mo	29c. Lice	17737	29d. E	Date signed (Mo	nth, Day, Year)
١	(PX)		30. Name end address of person who co	mpleted daluse of death (Item:	23a) (Type, Pript) Hospital Drive	" Cheverle	MD;	20785	
	Sta Registr		31. Dete filed (Month) Pay(Year) 200	32 Registrer's Signat	ure Joseph	l			

Division or Vital Records, P.O. Box 68760

3altimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

13000 Georgia Ave.,

₩egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Byoung Kie Lee, MD

JUL 06

31. Date filed (Month, Day, Year)

021033

Silver Spring, MD

July 3, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 2007 Queen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne trouble 1 AAMC If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yo 4/9/28 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Months Days Hours 79 215-26-2404 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10a. State 10b. County Y⊟Yes 2 No P.G. Upper Marlbora MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 16400 Halloway Court 20772 U.S. Pages 1 and 2 should be filed within 72 hours after death venent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify:Black altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Violet Owens William Queen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary L. Queen- Wife 16400 Halloway Ct. Upper Marlbora, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Harmony 7/5/07 Mem. Park Landover, MD 4 □ Donation 5 □ Other (Speg 22 Name and Address of Facility 21. Signature of Funeral Service Reese Professional Funeral Services 3605 14th St. N.W. Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ulcer Sequentially list conditions, any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Dementia burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death

Director: ,

d in by the f Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 006173 30. Name and address f per in who completed cause of death (Item 23a) (Type, Print) Medic 2001 Chang Chon 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

		1	1 - For State Registrar	State of Ma	arylan		artment o				giene Reg. No	7	2.54.20
	Physici /Medic		1. Decedent's Name (First, Middle, La: Margaret Mar	xine]	Ralsto	n			2. Date of Dea Month July	5, Day 200	Year 7	3. Time of Death 4:06 PMM
	Examin	er	4a. Facility Name (If not institution, give Moran Manor Nurs. 5. Social Security Number 6. S.	ing Home		last birthday)	West	ear If Under	r 24 Hrs.	8. Date of Birth (Month, Da)	4c. County Alle	gany	elace (State or Foreign
	Director Mode	_	218-16-3878	□M 2 X 0 F 8.		Yrs. y, Town or Lo	cation	iya Tioura]	Nov. 24	, 1923	Mary	71and Od. Inside City Limits 1ÅYes 2□No
	with the Ma e or 28a-f	Directo	10e. Street and Number 110 Chestnut			Web ce.	10f. Zip Co	1562			10g. Citizen of W		ntry?
036	should be filed within 72 hours after death with the Maryland Af Mental Hygiene. marked other then 'naturel', or iteme 23e or 28e-f ehow imatic event, the Medical Etaminal must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes Ş Ş Ş			Was Decedent If Yes, specify (ecify Yes or No- Rican, etc.)	14. Race Blace Specify	k, White,	
21215-0036	ed within 72 ho rgiene. Ier then "natur I, the Medical	Completed	15. Decedent's Er (Specify only highest gra Elementary/Secondary (0-12) UNKNOWN	ide <i>completed)</i> College (1-4or 5	i+)	(Give	dent's Usual Oo kind of work do DO NOT use re nemaker	one during mo atired)			House	work	dustry
Maryland	iould be filed I Mental Hygi narked other natic event, ii	To Be		erling		1.2		I	Marga	ret Fa	Maiden Sumam zenbakei	c	
e, Mar	1 and 2 st Heelth and em 27 ls n ther traun		19a. Informant's Name/Relationship (Robert B. Ralstor 20a. Method of Disposition			110 (t St, V	Veste		Marylar 20c. Location -	nd 2	21562
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If item 27 Is marked eny injury or other traumatic es 900.9.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Service Licer)	y)		ırel Hi	natory or other L11 Ceme	etery	200	/	Barton, ral Home	Mary	
B B	permi Depa Impo eny ii		7- Wayne 23a. Part1. Enter the disease, or com	e Sol	I the deat	11	11 Chur	ch St.,	, Wes	ternpor	t, Mary		21562 Approximate
1760,	Physician /Medical Examiner price priging in and price price in a control of the	cal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as Due to (or as Due to (or as Due to (or as	a conseq	uence of):	Chin	nic Ot	str	uclno	Lenz D	esem	Interval Between Onset and Death
P.O. Box 68	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the buriat-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3[Ectopic pregn Other (specif				23d. Dat Mo	e of deliventh	ery Day Year
rds, P.	quires thet n signed by uld be deta		Part II. Other significant conditions of	Senil	1	Den	renta		I.		obacco use conti res 2 \(\text{No} \)		he cause of death? pably 4 □Unknown
Division of Vital Records,	The la ate has page 2	Completed	CORENAR	p ARTE	ERIX	Q	istA.	SE		24a. Was autop perfor	rmed2 c	orior to co death?	opsy findings available impletion of cause of
Vita	sicien certifi rector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	NOT 2	ER/Outpatier	2 DOA	Other		(Check only o		or (Coose	4.1
ion of	ding h. After fune	atlon: To	27. Maprier of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da)	ry	28b. Time o Injury	f 28c.	Injury at Work?			dence 6 Oth		<i>y)</i>
Divis	2 # # c	Certification:	3 Suicide 6 Could not be determined		ury - At h c. (Specif	ome, farm, sti	reet, factory, of	fice		28f. Location (S City or Tox		er or Run	al Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of the best of the basis of and manner sta	f examina	owiedge, deat ition and/or in	h occurred at ti vestigation, in i	ne time, date a my opinion, de	and place, eath occurr	and due to the ded at the time,	cause(s) and ma date and place,	nner as s and due t	tated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier					cense number			29d. Date signed	d (Month,	Day, Year)
			> S. Chan	g-mg	> ~		1	256	38		July	6	2007
		5	30. Name and address of person who	completed cause of d			Print)	Fa	01 t b	ing d	MARYL	AN	N 21337
	Sta Registi		31. Date filed (Month, Day, Year) JUL - 6	32. Registra 2007	-		Speck D	4		7			/ &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

iathan Rubinstein	1- For State	of Maryland / Departi Certi	ficate of Deati		Reg. N	lo.	231.0
Physician/ Medical Examine					2. Date of Death	100 100	3. Time of Death 1615 hrs
Wedical Examine	4a. Facility Name (if not institution, giv			own, or Location of Death	July 8, 2007	4c. County of Deat	
Funeral	Suburban Hospital 5. Social Security Number 6. Se	ex 7. Age (In yrs. last	Bethe	esda er 1 Year If Under 24Hrs	. 8. Date of Birth(M	Montgomery M/DD/YYYY) 9. Bi	rthplace (State or
Director	578 – 38–5892	м 2 г 83	Yrs. Month	s Days Hours Min.	Aug. 10), 1923 Forei	gn Washington ountry) Washington
any.	Usual Residence of Decedent 10a. State 10b. County		own or Location				10d. Inside City Limits
aryland 8a-f show at once.	MD Montgome	ry	er Spring	Codo	1100	Citizen of What Cou	1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.		World Blvd. #72		0906	. Iog. C	U.S.A	
r death with or items 23 must be no	11. Marital Status 1 Never Married 2 Married			nt of Hispanic Origin? (Sp iy Cuban, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,
s after do	3 Widowed 4 Divorced	1 X Yes 2 TNo If Yes, Give Year US Arm	. <u> </u>	X No specify:		Specify:	hite
2 hours "natu	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of wor	Occupation (Give kind of viking life. DO NOT use reti	red)	b. Kind of Business	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	12		Commodity	Industry Spe	e(First, Middle, Maid		Commerce
215-15-15-15-15-15-15-15-15-15-15-15-15-1					cca Resnic		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (T Stanley Rubinstei		19b. Mailing Address 19023 Abb	(Street and Number or I ey Manor Dr	Rural Route Number , Brookev	City or Town, Stat	e, Zip Code) 20833
rre, N s I and f Health If item	20a. Method of Disposition 1 X Burial 2 Cremation 3		ace of Disposition (Nar ematory or other place)		Date 20	c. Location - City o	r Town, State
ti Page rtment orrant:	4 Donation 5 Other Specify 21. Signature of Funeral Service Licer	Kin		m. Gard. Ju			
Baf permi Depar Impo	23a. Part I. Enter the disease, or comp	1 ()					uneral Home 20012
Physician /Medical	failure. List only one cause on ea	ach line.					Approximate Interval Between Onset and Death
caminer	Immediate Cause (Final disease a. or condition resulting in death)	Multiple injuries Due to (or as a consequence of):	car licated	by hypertensive Lar disease	ameroscie	TOLIC	1
in the second	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a consequence of):					-
ted nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					+
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit hvs.ician/Medical Ex	d. X UNPENDED						-
'60, ate be execut obysician and e burial - tra	IF FEMALE:	AMENDED #23a,PII,27,28a-	f, perME,g873	3, 11/2/07 TT		23d. Date of delive	ry
certifice of use as the cian/		Live birth Pregnant at time of deat	2 Fetal death th 5 Other (Spe	3 Ectopic pregnacify)	ancy	Month	Day Year
). Box 687 the death certific by the attending plothed for use as the	1 Yes 2 No 9 Unknow	9 Utiknown			23e. Did tobac	cco use contribute t	o the cause of death?
, P.O. B res that the d signed by the be detached d by Phy	Hypertensive athe	erosclerotic cardio			1 Yes		obably 4 🗸 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical E.		· · · · · · · · · · · · · · · · · · ·			24a. Was an autopsy	prior to	autopsy findings available completion of cause of
Rec				26.Place of Death (Check	performe 1 ✓ Yes 2		
f Vital Physician Pris certi ral director	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 E		IOthor:		sidence 6 Oth	er:
n of ding Plan. h. After a funeral		(Month, Day,Year)		28c. Injury at Work? 1 Yes 2 X No	28d. Describe how		6 1
Division o Division o Spital or Attending sours after death. meral Director: Aft filled in by the fune	2 Accident Investigat 3 Suicide 6 X Could not	28e Place of Injury - At hon	and 1412 hrs. ne, farm, street, factory		28f. Location (Stre	et and Number or F	from window Rural Route Number, City
Div	4 Homicide determine	d (Specify) Assisted	Living facil				e. Silver Sprin
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I	(Check only 1 Certifying Physic one) 2 Medical Examine	ian: To the best of my knowledge r:On the basis of examination and and manner stated.					
F % F 8 G	29b. Signature and title of certifier	. ~	29	c. License number		9d. Date signed (M	lonth, Day, Year)
	30. Name and address of person who	completed cause of death (flem?	miD,	O.C.M.E.		uly 10, 2007	
	Theodore M. King, Jr., M.	D. Assistant Medical Ex	kaminer 111 Po	enn Street, Baltimoi	re, MD 21201		
Stat Registra	11.11 / 17 / 11	07 37 Registrar's Signatur	poste				

			For State Registrar	.00	State o	of Man	yland		artmen rtificate			and M	lental Hyg	iene	E E	2)	422
			1. Decedent's Name (First, Midd.	e, Last)	-								2. Date of Deat Month	h Day	Year		of Death
	Physici /Medio		EDDA MARI	Α :	ROCHA	A			,				7/9/2	0.07			07 A M
	Examin		4a. Fecility Name (If not institutio	-					,		Location o			4c. County			
			Garrett Cou		Memo						klar		O Date of Birth	Gar	ret		to or Foreign
ı	Funeral Director		5. Social Security Number 233-88-2971	6. Sex 1 □	M 2 ⊠ F	-	7 5	nst birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month, Day, 9/28/	1 ^{Year)} 1	Br	azil	te or Foreign
	pu *		Usual Residence of Decedent 10a. State 10b. County			10	Oc. City.	, Town or Le	ocation							10d. Inside	City Limits
	f eho	5		sto	n		Te	rra i	Alta							1 □ Y	es 2 No
	the 28s	Je C	10e. Street and Number						10f. Zip	Code			10	0g. Citizen of	What Cou	untry?	
	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-f ehow I.a Medical Examirar must be motified at	Funeral Director	241 Rhodode	ndr	on Dr	rive			26	764				Brazi	1		
	deatl	ner	11. Marital Status	12	2. Was Dec	edent Eve	er in U.S	S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spo	ecify Yes or No- Rican, etc.)		ce - Amer	rican Indian	,
ထ္ဆ	or its	르	1 Never Married 2 Mar		1 ∐Yes If Yes, Gi	2 No			1 Yes		Specify:					casia	n
21215-0036	uraf,	Completed by	3 XWidowed 4 □ Divorced		Year or D	Dates:		160 Dans			et an			16b. Kind of B	ueinace/l	nductna	
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12	the.	E	Elementary/Secondary (0-12)		College (1-4or 5+)			Iomen					Dome	sti	С	
ğ	othe ont,	BeC	17. Father's Name (First, Middle,								18. Mothe	r's Name	First, Middle, M	Maiden Sumar	ne)		
<u> a</u>	uld be Menta rrked	To E	Epaminondas	Lop	pes I	e Ca	ast:	ro			E N	oem	ia Mene	ezes D	e Ca	astro	5
Maryland	2 sho and ? is ma		19a. Informant's Name/Relation		-			19b. Maili	ng Address	(Street a	and Numbe	or Run	al Route Number	, City or Town	, State, Z	ip Code)	
≥	ealth m 27		Michael H.	Rocl	na		anh Bi	RR ace of Disp	1 Bc	x_3	49F,		rora, M	V 2	670		
ore	t of H If ite or oth		20a. Method of Disposition 1 1 Burial 2 ☐ Cremation	3 □Re	moval from		Ce	metery, cre	matory or o	ther plac	e)	7/1	1/2007				
Baltimore,	then tent:		° 4 Donation 5 Dother (Te	rra <i>I</i>						Terra			√ V
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show emportent; in the 23a or 28a-f show empiriety intry or other treumatic event, the Medical Exercities must be notified at an inc.		21. Signature of Funeral Service	License	wing	5		1	os H	r H igh	land	igh Av	t Funer enue, I	al Ho erra	me Alta	26 W	5764 1
,092	/Medical hysician and principle burial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated ovents resulting in death) Last	6.	Due to	(or es a c	consequ	ence of):	^							3 1	on this
.O. Box 68	death certificate e attending phy: id for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23		birth 2 (nant at tim	Fetal	death 3	⊒Ectopic pr ⊒ Other (sp						ate of deli	very Day	Year
ds, P	8 50	ρ	Part II. Other significant condit	ons cont	ributing to d	death but r	not resu	ilting in the u	inderlying o	ause give	en in Part I		23e. Did tot	oacco use con			of death?
Ö	w requir been si should I	etec		green of the	/								24a. Wasa	n 24b.	Were au	topsy findir	ngs available
Records,	Pe age	Completed											autops perforr	ned?	prior to death? 1 ☐ Yes	completion	of cause of
Vital	Physicien: This cartificate rai director, p	Be	25. Was case referred to medical examiner?	-	- 2-1							of Deat	h (Check only on	e)		SC-1115	
of \	Physic this c	၉	1 Yes 2 140	H		Inpatient		ER/Outpatie	_		4 🗆 140	ırsing Ho	me 5 Reside			cify)	
Ĕ	ding P. After funera	lon	27. Manner of Death 1 ☑ Matural 5 ☐ Pendi		28a. Date (Mor	nth, Day Y	'ear)	Injury	M	8c. Injun Work	γαι k? Yes 2	No	280. Describe no	ow injury occu	1100		
Division	r Attending er death. rector: After by the fune	Certification;	2 Accident Invest 3 Suicide 6 Could 4 Homicide deten		28e. Plac	e of Injury ding, etc. (- At hor (Specify)	me, farm, st			.03 20		28f. Location (St City or Town		ber or Ru	ral Route N	√umber,
۵	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	ai Cer											and due to the c				(-)
	he Hk in 24 he Fu pieteli	edicai	one)			nner state		ion and/or ir				un occur	red at the time, d				
		Σ	29b. Signature and title of certific	Sr /				1	290	. License	e number	//	2	9d. Date signe	ed (Month	n, Day, Yea	r)
	8		1	h	2	XC	on	to		11 4	14	6		7/9	107		
			30. Name and address of person		6										, -		04.55
			Sotiere Savo			M.D Registrar's			. For	ırth	st.	, S	uite 1,	Oak.	Land	, MD	21550
1.00	Sta Regist		31. Date filed (Month, Pay, Year	3 20	107	A STANK	3.00 g	A A	Sand.	P							

		State Registrar 1. Decedent's Name (First, Middle, La	et)	Cei	rtificate of	Death	Reg. No. 2. Date of Death 3. Time of Death				
Physici /Medio		FLORA			SHUH		Month 07	Day Yes 07 0	7 0845 ^M		
Examir	ner	4a. Facility Name (If not institution, giv WMHS-BRADDOCK CA			CUMBERL	r Location of Death	4c. County of Death				
Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	ALLEGANY 8. Date of Birth 9. Birthplace (State or Fo				
Director		214-07-1819 Usual Residence of Decedent	1□м 263% 96	Yrs.	Months Days	Hours Min.	Jan. 21	, 1911 Ma	aryland		
e Maryiano 3a-f show tiffed at	Director	MD. 10b. County Allega		Barto					10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
th with the 23a or 28 ust be no	al Dire	10e. Street and Number 18915 High	St.		10f. Zip Code 2152	<u>?</u> 1	10	og. Citizen of What United S			
permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 35√Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes ※XX No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc. white		
hin /2 nou e. an "natura Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Give		during most of work d) _	king	16b. Kind of Busine			
giene giene er th	Б	unknown			Nurses Ai	_d		Nursing	nome		
uld be like Mental Hy rked oth tic event	To Be (17. Father's Name (<i>First, Middle, Last</i> Claude	Snyder			Mai	e (First, Middle, M rie Ross	3			
and 2 shore		19a. Informant's Name/Relationship (Iowell Snyder/ n		19b. Mailir 45 P	ng Address (Street arsons Av	and Number or Rule., Bloom	ral Route Number, mington,	City or Town, State Maryland	^{9, Zip Code)} 21523		
Pages 1 and the nent of He nent of He net if item arry or other		20a. Method of Disposition 1 ☐ Burial 2℃CPremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Themoval nom State	Ob. Place of Dispo cemetery, crei Cumberla	esition (Name of matory or other pla nd Cremat	ory 07	/^^/	20c. Location - City Cumberlan	or Town, State d Maryland		
permir. Departn Importa any inju		21. Signature of Funeral Service Lice	nsee bord		ess of Facility Boo		al Home , Maryla	nd 21562			
Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	polications that caused the one cause on each line. a. Sepsis	death. Do not ent					Approximate Interval Between Onset and Death		
cate be executed physician and ithe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord) C. Due to (or as a cord) d.						jodays.		
The law requires that the death certificate is the has been signed by the attending physic bage 2 should be detached for use as the bage 2.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes → No 9 □ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnanc] Other (spe <i>cify</i>) _	у		23d. Date of Month	delivery Day Year		
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. The law requir cate has been si page 2 should I	Completed				24a. Was ar autops perform 1 Yes 2	24b. Were prior death					
iclan: In certificate ector, pag	Be (25. Was case referred to medical examiner?	Hoonital:		100		th (Check only one	9)			
Prnysi this o	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatier		4 LI Nuising A	ome 5 Reside	nce 6 Other (S	Specify)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director;	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	(Month, Day Yea	ar) Injury	M 1□	rk? Yes 2□No			Rural Route Number,		
ottal or A		4 ☐ Homicide determined	building, etc. (S	pecify)			City or Town	, State)			
24 ho 24 ho Fune	Medical		hysician: To the best of my miner: On the basis of exa and manner stated.								
within To the comple	Mec	29b. Signature and title of certifier	01 ·	MO	29c. Licens			od. Date signed (M			
		, monent	mu !	(Ham 00 -) (Tim	Doo (55525		July 07	7,2007		
		30. Name and address of person who									

			For State Registrar	State of Marylan	-	irtment of F <i>tificate of</i>			giene Reg. No. (g]	991.51		
ľ			Decedent's Name (First, Middle, Last	et)				2. Date of De Month		3. Time of Death			
	Physici /Medic		Mary Fay Shott					July	9	2007	8:50 P.™		
	Examir	ner	4a. Facility Name (If not institution, give	,			r Location of Deat	th	4c. County of Death				
	Funeral		5. Social Security Number 6. S		last birthday)	Cumber If Under 1 Year	Land If Under 24 Hrs	8. Date of Birl	A11egany				
	Director		220-30-8571	□ M 2□XF 73	Yrs.	Months Days	Hours Min.	Nov. 23	y, Year) 3 193:	(, Year) Country)			
	pu ,		Usual Residence of Decedent 10a, State 10b, County	100 Cit	v. Town or Lo	ootion				1	0d. Inside City Limits		
	faryla shov ed at	ō			,					'	1 Ty Yes 2 No		
	the N 28a- notifi	Director	MD Allegar 10e. Street and Number	iy Cui	nber1a	10f. Zip Code		-	10g. Citize	en of What Coun			
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	ems;	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14	4. Race - Americ Black, White,			
36	be filed within 72 hours after death with the Maryland that Hyglene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1		I∐Yes 2.XNo	Specify:			Specify: Whit			
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Mar	and 2 sealth ar n 27 is		Dawn E. Phillipp			Box 571			-				
Š.	ter Iter		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	20b. F	Place of Dispo	sition (Name of natory or other place	i i	Date		ation - City or To	wn, State		
Ĕ	Pages ment of I ant: If its jury or o	0	4 □ Donation 5 □ Other (Specify		nart Ce	emetery	7/1	1/07	Echa	art, MD			
saltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licen	Rindan	22	. Name and Addre David A.	ss of Facility Burdock	. Funeral	Home	2			
	102 00		23a. Parti. Enter the disease, or com	plications that caused the deat	h. Do not ente		cond St.			21550	Approximate		
	Physician	8 9	shøck, or heart failure. List only i Immediate Cause (Final	one cause on each line.	0 /	7/4		,	,		Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	a. Due to (or as a cove eq	uence of):	youph	OMM				OMOL		
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1 4	led sit	niner	Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse ;	uence of):					1			
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ž Q	death cert e attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	l death 3□	Ectopic pregnanc	y		23	d. Date of delive Month	ory Day Year		
5	the de	ysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5∟	Other (specify) _							
S, J	w requires that the death certil been signed by the attending should be detached for use a	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use	e contribute to the	ne cause of death?		
	equires en sign							1 🗆 '	Yes 2	No 3 □ Prob	ably 4 Unknown		
ecora	law re as bei 2 shc	Completed						24a. Was		24b. Were auto	psy findings available inpletion of cause of		
<u> </u>	ilcian: The lav certificate has ector, page 2	Com						perfo	rmed? 2 No	death?	2 □ No		
VITAI	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		t 3D DOA Oth	or	ath (Check only o					
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	To the Hospital or Attending Physical Within 24 hours atter death. To the Funeral Director: After this completely filled in by the funeral discompletely filled in the funeral discompletely fille		and the state of t	T- the best of white									
	24 hor Fune etely f	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	ysician: To the best of my knoniner: On the basis of examination and manner stated.	iwledge, death ition and/or in	vestigation, in my	me, date and place opinion, death occ	e, and due to the urred at the time,	date and p	and manner as st place, and due to	tated. the cause(s)		
	Fo the Fo the complex	Me	29b. Signature and title of certifier	7		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)		
			<i>→ 1/1000</i>	Egge MM	2	D22	181		July	10, 20	07		
		2	30. Name and address of person who			Print) shop Wals	ah Daire	Cumbon	land	MD 21	502		
	C4-		Gary L. Was	goner, M.D.,		onop wars	DI TVE	, yamber.					
	Sta	ite	114 1 9	ana A		d							

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasneem Makik, M.D. CARROLL 31. Date filed (Month, Day, Year)

JUL 0 6 2007

4 Homicide

(Check only

29b. Signature and fitte of certifier

29a, Certifier

one)

AVENUE

and manner stated.

MD

TAKOHA PARK

🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 59121

29d. Date signed (Month, Day, Year)

200

gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra AMFND#260erIMD7/6/07, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** $\widetilde{P}^{\;\mathsf{M}}$ Bess /Medical Μ. Smith 2007 11:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville
If Under 1 Year | If Under 24 Hrs. 1801 East Jefferson St. Mountgomery

9. Birthplace (S
Country) APT. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** State or Foreign Min 1 M 2 XF Months Days Hours Director 92 064-10-8953 9/12/1914 Bronx, NY. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 X Yes 2 No MD. Montgomery ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 East Jefferson St. Apt. T17 Funeral 20852 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If fem 27 is marked other trainmant. Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Chasen Israel Orenstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alyssa Smith / granddaughter 905 gentlewood st. gaithersburg, md. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ∏ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 Donation 5 Dother (Specify) Beth David Cem. 7/2/07 Elmont NY. 21. Signature of Funeral Service Licensee 2Danzansky G5Tdberg 1170 Rockville Pike Rockville, Md. 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAL INFARCTION resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions many, leading to mine dial cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) The law requires that the death certificate be Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 Yes Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 XYes 2 □ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0180 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) gistrar's Signature State JUL 0 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 2007 9:00 A JULY ROBERT L. STEELE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Days Hours 1 X M 2 □ F Yrs. MICHÍGAN Director 380-50-7975 20,1948 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show 1 ▼Yes 2 No , or Items 23a or 28a-f sh aminer must be notified Director NONE WASHINGTON D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 600 CEDAR ST. N.W. 20012 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ 3 Widowed 4 Divorced WHITE 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) COMPUTERS 5+ PROGRAM DEVELOPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT Τ., STEELE SR. RUTH HUMES 2 NANCY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 600 CEDAR ST. N.W., WASHINGTON, D.C. 20012 RORSTROM-LEE/WIFE JERALDINE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 7-5-2007 21. Signature of Funeral Service J 22. Name and Address of Eachty
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ANOXIC ENCEPHALOPATHY 3 WEEKS /Medical Due to (or as a consequence of): Examiner CARDIOPULMONARY ARREST 3 WEEKS Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit 3 WEEKS ARDS Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown DIABETES TYPE II, HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? ASPIRATION PNEUMONIA, MULTISYSTEM ORGAN FAILURE 24a. Was an autopsy 2 □ No 2**∑**No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident Injury 1 □ Yes 2 □ No 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C t 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0065485 Esparisch Rem Mp 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GLEN RD., SILVER SPRING, MD. 20910 SUPANICH, M.D. BARBARA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 6 2007

egistrar's Signature

Physician /Medical Examiner

P.O. Box 68760.

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2,^{Day}2007 Natalia Stepina July 11:28pM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Southern Maryland Medical Center Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 / 04 / 1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 🛛 F 83 Russia none Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County or 28a-f show notified at 1 □Yes 2 No Brandywine MD Charles Director death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n 20613 Russia 4080 Turner Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or Items Medical Examiner mu permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item
any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) University Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valentina Shulgina Mitrofan Chernyshov P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4080 Turner Road Brandywine, Md. 20613 Irina Carroll/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/06/2007 Washington, D.C. Rock Creek Cem. 4 □ Donation 5 □ Other (Specify) PHITE TOPA OF SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician STROKE /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner HYPERTENSION certificate be executed use as the burial-tran and Due to (or as a consequence of): attending physician for use as the buria FIBRILLATION ATRIAL Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ HEARS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 page performed? res 2 No 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier maustano

State Registra

OKON HILL

ROAD #500

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

OKON HILL

32. Begistrar's Signature

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The control of the				·	Sex 7. Age 1 M 2 🔏 F							8. Date of Bi	ate of Birth 9. Birthplace (State of Locality) 12, 1929 England						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b, per Inf of Maryland Department of Health and Mental Hygiene 1- State Registrar Amend #1, perDoc. G869, 7/20/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Raymond Elroy Spencer, Jr. 3 Time of Death **Physician** Raymond June 30, 2007 1552 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Chever1v Prince Georges If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days 1**X** M 2□ F 577-94-9365 August 11,1961 Fairmont Hts.Md Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10h. County r 28a-f show notified at 1 Yes 2 No Maryland Prince Georges Hyattsville Director 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or ; 6714 Stanton Rd. 20784 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black It Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than " College (1-4or 5+) Elementary/Secondary (0-12) Private Print Pressman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any injury or other traumatic event ones. Evelyn Isom Raymond Ε. Spencer, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1813 Billings Ave. Capitol Heights, Md. Philesa A. Spencer / Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Cetar Hill Cameter) (anteter)
Lincoln Memorial 1X Burial 2 ☐ Cremation 3 ☐ Removal from State July 7,2007 Suitland, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Alexander S. Pope P.A. 5538 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Servic, Lio nsee Durge M01085 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dulmonan /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Pulmon Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death 9∏Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Yes 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred After Injury Natural 5 □Pending 1 ☐ Yes 2 ☐ No investigation death. ☐ Accident **Director**: 6 Could not be determined BIT Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dr. Niwe Hichardson, D.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Sulphy Steven 32. Registrar's Signature.

Micale Kickardson

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Joseph TAHA July_ 10:00 PM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sligo Creek Nursing Home Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F Yrs. Director 1919 Unknown 579-42-2805 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No **Brookeville** Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20833 United States 18668 Queen Elizabeth Drive or Items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status unknown Black, White, etc. e filed within 72 hours after al Hygiene.
other then "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Grocery Store 12 General Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be tilt Department of Health and Mental Hy Important: If item 27 is markad oth any injury or other traumatic event 2008. Be unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20833 18668 Queen Elizabeth Drive, Brookeville, MD Zev Halpern, Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery! 07/06/07 Adelphi, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carro 11 St., NW, Washington, DC Do not enter the mode of dying, such as cardiac of respiratory arrest, 20012 23a. Partition for the disease, or complications that caused the dyafth. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a co Examiner Sequentially list conditions, any language immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit that the death certificate be executed and Due to (or as a consequence Records, P.O. Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Dinknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 10,0 mo 7**a**S performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medicar examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Usersing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Libertural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check on one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20912 Nasreen Kango, M.D., 7610 Carroll Ave., #205, Takoma Park, MD 31. Date filed (Month, Day, Year) **31.** Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item? per doc 8869 7-23-07 vt
State of Maryland? Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 2007 1. Decedent's Name (First, Middle, Last) Month, Day WB Y THAMES 0 01 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) PRINCE PRINCE CHEVERL GEDRGES GEDRGES HOSP CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🂢 F 1929 VIRGINIA JULY 11, 223-32-8151 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 XYes 2 No PRINCE GEORGES BLADENSBURG MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5999 EMERSON ST. 20710 #625 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BUS DRIVER PUBLIC SCHOOLS 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GRAHAM Α. FLINT BERTHA HENSEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) THAMES / SON 1635 SHORE DR., EDGEWATER, MD. 21037 LARRY W. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM. 7-9-2007 CHELTENHAM, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A
M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 207 21. Signature of Funeral Service Licensee 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC CARDIOMYOPA 3 WEEKS Due to (or as a consequence of): M 40 CASAI ANC UTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FFMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death in the past 12 months? 1 ☐ Yes 2 No Month Day Year 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? SMAL NOUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy RENA 1 Yes 2 № No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: patient 2 ER/Outpatient 3 DOA 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

and attending physician a I for use as the burialas signed by the a after death. in by the To the Hospital c within 24 hours af To the Funeral D completely filled i

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE 25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide

29b. Signature/and title of certified

29c. License number

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 200

800' 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GATE LYDIA GILBERT-MCCCAN BOW

State Registrar 31. Date filed (Month, Day, Year)

egistrar's Signature

			1 - For State Registrar	State of Maryland		artment of F			jiene eg. No. 2)7	23433
			Decedent's Name (First, Middle, Last)			<u></u>		2. Date of Dea Month		rear .	3. Time of Death
	Physicia /Medic		MARGARET	G. THOMP	SON			JULY	2, 200	7	3:52 A M
F.	Examin		4a. Facility Name (If not institution, give s	treet and number)			r Location of Dea		4c. County of		
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<u>lar</u>	should be nd Mental marked o	10	FRANK F	. KIDWELL							
Maryland	C1 00 68		19a. Informant's Name/Relationship (Type	pe, Print)	1	ing Address (Street					
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Baltimore,	permit. Pages Depertment of H important: if ite any injury or of		21. Signature of Funeral Service License	· · · · · · · · · · · · · · · · · · · ·	091	2. Name and Addro CHAMBERS 5801 CLEV	FUNERAL ELAND AV	HOME & C	REMATORI RDALE, M	UM,P D. 2	o737
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Division	호 # 등 드	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		street, factory, office	1	City or To		ar or murai	r Aquite Number,
	To the Hospital within 24 hours of To the Funers! completely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, dea ition and/or i	ath occurred at the investigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and mar date and place, a	nner as stand due to	ated. the cause(s)
	within 2 To the comple	Mec	29b. Signature and title of certifier	1		29c. Licer	ise number		29d. Date signed	(Month, I	Day, Year)
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	6		30. Name and address of person who co	ompleted cause of death (I	23a) (Type	7	J.J. I.		3021 2	_ , 0	
				TANA, M.D.		HERITAG	E PARK C	IR., SILV	ER SPRIM	NG, M	D. 20906
		ate	31. Date filed (Month, Day, Year)	32 Degistrar's Signa							
	Regist	rar	.rur 0 6 200	IT Alexand	1. A	DOMES!					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Conni	ie Marie Tra		1- For State	Stat	e of Marylar					Mental	Hygi		ı. No.	jį	7 2340	
Medi	Physicia cal Exami	an/	1. Decedent's Name	For State Certificate of Death Decedent's Name (First, Middle,Last) Connie M. Trainor a. Facility Name (if not institution, give street and number) Randolph & Nebel Train Tracks Certificate of Death 4b. City, Town, or Loca Rockville								ate of Death	Day Year		3. Time of Death 1725 hrs	
I.					-	nber)		-		ocation of De	ath		4c. County of Montgom			
	Funeral Director		5. Social Security N 524-34-1		Sex 7	7. Age (In yrs. Ia		Month	er 1 Year ns Days	If Under 24I	Ain.			Foreign	1	
			Usual Residence of		M 2 <u>A</u> _F	75	Yrs	<u>:</u> .l		<u> </u>		March	21,1932		^{intry)} Colorado	
	w any		10a. State	10b. County	•		Town or Locat	ion							10d. Inside City Limits	
	Maryland 28a-f show d at once.	ig	Maryland 10e. Street and Nu	Montgo	mery	Rock	kville	10f. Zip	Code	-		10	g. Citizen of Wha	t Coun	1 X Yes 2 No	
	the Mai 1 or 28 Liffed a	Director	5213 Bre		Drive			1	0852				ited St		•	
	h with ems 23.	Funeral	11. Marital Status	ed 2 Marr	A	edent Ever in U.				anic Origin? (14. Race - White,		can Indian, Black,	
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	ours af atural	d by			or Dates: y only highest grade	e completed)	16a. Deceder	nt's Usual	Occupation			done	16b. Kind of Bus			
9	56 in 72 h han "n lical E:	Completed	Elementary/Second 1.2	ondary (0-12)	College (1-	4 or 5+)	Homem		irking ille. t	DO NOT use	retired)		Own Hor	Own Home		
	5-0036 lled within 7 Hygiene. I other than the Medica	Com	17. Father's Name	(First, Middle, La	ast)		Tromem.	uncı					aiden Surname)	-		
	21215 ould be file Mental H marked ic event, f	Be	Paul Gr						- 1	lice B						
9	Baltimore, MID 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked ofter than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	₽	19a. Informant's Na Suzanne I		Daughter/								re, MD			
	re, N I and I Health If item			a. Method of Disposition Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Front Tipe of The Creme to available of the control of the c									20c. Location - 0	City or	Town, State	
	Baltimore, permit. Pages I at Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: Frot Lincoln Crematory									13,200	7 Brentwo	ood,	, MD	
1	Balt permit, Depart Impor injury			Signature of Funeral Service Licensee 22. Name and Address of Facility									ute, 104 ille, MI	40 F	Rockville	
	Physician		23a. Part I. Enter th	n Gasch ne disease, or co nly one cause or	emplications that ca			he mode	of dying, s						Approximate Interval Between Onset and	
ſ	/Medical vaminer		Immediate Cause ((Final disease	a. Multiple Inju								· 	_	Death	
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B	uted Id ansit	Examiner	(Disease or injury t events resulting in		Due to (or as a	consequence o	of):									
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	68760 certificate nding phys se as the b		IF FEMALE: 23b. Was decedent past 12 months			outcome of preg	inancy	etal death	. [Ectopic pre	gnancy		23d. Date of o) Day Year	
•	Box 68766 he death certificate the attending physical for use as the beatter	sician/M	1 Yes 2		·	ant at time of de		ther (Spe	ecify)							
	cords, P.O. Box 68760 law requires that the death certificate has been signed by the attending phy: 2 should be detached for use as the b	, Phy	Part II. Other signi	ificant conditio			esulting in the	underlying	g cause gi	ven in Part I.	-	23e. Did tol	pacco use contrib	oute to	the cause of death?	
- 1	ing Physician: The law requires that the law requires that the After this certificate has been signed by tuneral director, page 2 should be detach.	ed by									_				pably 4 Unknown	
•	ord aw req has bee	Completed				.					_	24a. Was a autops perfor	sy pr		topsy findings available completion of cause of	
1	Rec i: The ificate r, page		25. Was case refer	red to medical	1				26 Place	of Death (Che	eck only	1 ✓ Yes 2		✓ Ye	es 2 No	
L	Vital ysician his cert directo	o Be	examiner?	2 No	Hospital: 1 tr	npatient 2	ER/Outpatien			Nils and			Residence 6	Other	: Scene	
,	sion of Vital Rec Attending Physician: The r death. ector: After this certificate by the funeral director, page	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 1 1720 hrs 1 Yes 2										ow injury occurre ck by train	d		
	Division of Vital Records, tall or attending Physician: The law requir is after death. Tal Director: After this certificate has been sted in by the funeral director, page 2 should led in by the funeral director, page 2 should	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could determ	not be 28e. Place	of Injury - At h		et, factory	y, office bu	uilding, etc.		or Town, St			ral Route Number, City	
	Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical C	29a. Certifier	Certifying Phy Medical Exam	sician: To the best	of my knowled	ige, death occu	rred at the	e time, dat ny opinion,	te and place, death occurr	and due	e to the cause e time, date a	e(s) and manner and place, and du	as state	ed. e cause(s)	
		Me	29b. Signature and		and manner st			29	c. License				29d. Date signe	d (Moi	nth, Day. Year)	
	0				Jeef				O.C.N	Л.E.			June 30, 20	07		
		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201														
	S	tate trar	31. Date filed (Mo	1. Date filed (Most) Pay feet 2007 32 egistrar's Signature												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** July 2, Dvoira USHMAN 2007 7:39A Vera /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 TF 94 Yrs Director Ukraine 359-66-6179 Dec 26, 1912 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 XYes 2 □ No Director Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Examiner must be Funeral 20852 United States Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. 6121 Montrose Rd 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No þ 3 ☑ Widowed 4 ☐ Divorced White "natural", Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Businesswoman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Musva (Unknown) ဂ Shmilek Shapiro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. 2320 Glenmore Terrace, Rockville, MD 20850 Inna Shapiro/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens July 3, 2007 3 ☐Removal from State Olney, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia /Medical resulting in death) Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2X No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an

JULY 02, 2007 USHMAN, DVOIRA within 24 hours a er death

To the Funeral Director:
completely filled in by the

Completed by Physician/Medical Be Medical Certification: To

25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No 27. Manner of Death 1 ☑Natural 2 ☐ Accident

29a. Certifier

29b. Signature and

3 ☐ Suicide 4 Homicide

6 Could not be determined

28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 🔯 Inpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

170061307

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month) Day, Year)

30. Name and add ass of person who completed cause of death (Item 23a) (Type, Print)

Atul Rohatgi, M.D. 8600 Old Georgetown Rd., Bethesda, MD 20814 31. Date filed (Month, Day, Year)

Registrar

egistrar's Signature JUL 0 5 2007

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 9:18 PM Strother Hendricks Watson 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Jan. 18, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** . 1913 Days Hours Months **X**XM 2□ F Yrs. 94 Director 236-01-8012 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov int: If Item 27 is marked other than "natural", or Items be notified at iny or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9636 Downsville Pike 21740 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes AXXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: Completed by 3√Widowed 4 □ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Load Dispatcher Utility 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Neill Watson Margaret Bane ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard N. Watson - Son 10034 Pleasant View Dr. Hagerstown, Maryland 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or Edge Hill Cemetery July 12,2007 Charlestown, Virginia 4 Dopation 5 Other (Specify) 21. Signature of Juneral Parvio Osborne Address of Facility Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aceila Myocardia
Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autopsy 2 **N**o Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within

WH-12

State Registrar

31. Date filed (Month, Day, Year) JUL 1 0 2007

ABD4L

29b. Signature and title of certifier

WATERD UD- 12821 -OAKHIL AVB HAGERSTOWN. MD21742 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

021459

29d. Date signed (Month, Day, Year)

200

		•	State of Maryland / Department of Health and Mo 1 - State Registrer Certificate of Death	ental Hygiei Reg.	7 11 1 1	23437
1				2. Date of Death Month	Day Year	3. Time of Death
П	Physicia /Medic	_	Frances Brehm Watson	June 29,2	•	1:31 P ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	h
			1002 South Schumaker Dr. Salisbury		Vicomico	
	Funeral		Months Days Hours Min.	8. Date of Birth 4/29/1938	9. Birt	nplace (State or Foreign untry)
L.	Director	}	193-30-9687 1 M 2 XF 69 Yrs. Monthlis Days Hours Willing	4/29/1930	Pen	nsylvania
	land	1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary -1-t-h	ğ	Maryland Wicomico Salisbury			1 AYes 2 □ No
	r 28a	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?
	3a ou		1002 South Schumaker Dr. 21804	US	SA	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itema 23e or 28e-f ehow ent, the Medical Examinar must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent ol Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ame Black, White	
ထ္	or its	Ē	1 ☐ Never Married 2 1 ☐ Yes 2 1 ☐ No Specify	110411, 010.)	Specify:	5, 6 10.
21215-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Wh	ite
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	Hygie ther ther	ပ္		(First, Middle, Maid		.rce_
ā	d be antal cod o	To Be	Victor Noble Brehm Frances B	outlos C	illotto	
Maryland	shou nd M mari	۳	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural			(ip Code)
_	nd 2 alth a 27 is r trai		Winfield Watson/Husband 1002 South Schumaker Dr	. Salisbu	ary,MD 21	804
ē,	of Height		20a. Method of Disposition 20b. Place of Disposition (Name of cametony crematony or other place)		Location - City or	
Itimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23s or 28s-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Scremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 7/2/0)7 Sa.	lisbury,M	aryland
a	permit. Departm Imports any Inju		21. Signature of Funeral Service Lioynes 22. Name and Address of Facility Holloway Funeral Hom	ne D A		
<u>m</u>	8 5 E 8		Keel Chiney (5) 501 Snow Hill Rd. Sa	alisbury,	Maryland	21804
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition _ a Adenocarcinona, Princery to	Per. to	neum	Onset and Death 2.5 year
	/Medical		resulting in death) Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b			
	sit s	ine	ir any, reading to immediate cause. Enter Underlying Cause, Disease or injury			
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687	ficate physis the	edicai	d		. 1	
×	certii nding use a	Z/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	ivery
P.O. Box	ires that the death certifications signed by the attending does detached for use at	by Physician/M	in the past 12 months? 1 Vos 2 No		Month	Day Year
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ις.	s tha	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ğ	w require been sly should t			1 ☐ Yes	2 X No 3 □ Pr	obably 4 Unknown
ည္မ	law re as be 2 sho	Completed		24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Ě	hysician: The law his certificete has t I director, page 2 s	mo;		performed	death?	2 No
ita	striffic ctor,	Be (25. Was case referred to medical examiner?	(Check only one)	· · · · · · · · · · · · · · · · · · ·	
×	hysic his co	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hon	me 5 Residence		cify)
ב	Attending Physician: The law requires that the death certificate rideath. actor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	on:	Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how i	njury occurred	
Sio	tend death tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury. At home farm street Jactory office	28I. Location (Stree	t and Mumber on C	and Courte Atumbus
Division of Vital Records,	F 8 F C	Certification;	28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)	City or Town, S	itate)	gran noble (variber,
_	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a	and due to the caus	e(s) and manner as	stated.
	24 h	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre one) and magner stated.			
	To th within To th	Me	29b. Signature and title of certifier 29c. License number		Date signed (Mont	h, Day, Year)
1	OA.		May 1 - 10 0 30690	J	420	2007
7	10					
\	109m		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1. 1	
`\	12gg		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tame 5 E. MADTIN M. S. 145 E. Carroll 5	7. 50	1:36007	MD
\	Sta Registr			t. 50	1:35007	MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day WASHINGTON Month Year 6:45 A M BARBARA 27 DINE ENO 7 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE LITY

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. 11/27/1945 JOHNS HOPKINS HOSPITAL 7. Age (In yrs. last birthday) 61 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Virginia 230-62-7223 1 □ M 2 TF Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Landover Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20785 1520 Sherwood Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gov't Contract Specialist 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Flossie L. Parker Henry Washington 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code 3742 A Towne Point Rd. Portsmouth, VA 23703 19a. Informant's Name/Relationship (Type, Print) 3742 ATowne Point Rd. Terry M. Davis/ Daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Resurrection Cemetery 7/5/2007 Clinton, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. Jenkins, Funeral Home 7474 Landover Rd. Landover, MD 20785 21. Signature of Funeral Service Ligense 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stag UPar Due to (or as a consequence of) Alcohol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 And 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death | Check only one

ng physicien and as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 signed by certificete

Examine Physician/Medical ģ Completed Be ဥ Certification: Medicai

Physician

/Medical

Examiner

Funeral

Director

or 28a-f ehow

other traumetic event, the Mudical Experimenment by notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Depurtment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23e any njury or other traumetic event, the Mental

Physician

/Medical

Examiner

by Funeral Director

Completed

Be

or Attending Physicien: After this death. I Director: A within 24 hours after To the Funeral Dire

State

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Nã 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1: Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

MD

29c. License number RES-000 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL, GOD N. WOLFE ST, BALTIMORE, 21287 HOPKINS , JOHNS ABBULNOUR

29b. Signature and title of certifier

32. Registrar's Signa ure

Registrar

			For State State Registrar	e of Maryland / [rtment of He tificate of L		nd Mei		ene g. No. 😘 📊	7.7	001.50
	Physicia		1. Decedent's Name (First, Middle, Last) GILBERT	WEAVER					Date of Death Month	Day 200	Year	3. Time of Death 6:10 P
	/Medic Examin		4a. Facility Name (If not institution, give street and SOUTHERN MARYLAND	d number) HOSPITAL		4b. City, Town, or			01111 20	4c. County	of Death	GEORGE'S
	Funeral Director		5. Social Security Number 214-36-4917 6. Sex	7. Age (In yrs. last bir	rthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, IARCH 2	Year) 1 1940	9. Birth Cou WASI	place (State or Foreign ntry) IINGTON, DC
	e Maryland a-f show tified at	ctor	Usual Residence of Decedent	10c. City, Town		ation NDOVER						10d. Inside City Limits 1√2 Yes 2 □ No
	h with the	al Director	10e. Street and Number 7115 EAST RIGGS DRIVE	2		10f. Zip Code	785		10	g. Citizen of V		ntry?
920	d within 72 hours after death with the Maryland giene. rr than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. d Forces? /es 2∭No s, Give or Dates:	If	/as Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)		k, White,	
21215-0036	within 72 ho iene. • than "natur the Medical E	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle 12th		(Give k life. D	ent's Usual Occupa ind of work done d O NOT use retired, RINTER	uring most o	of working	1	6b. Kind of Bu		ŕ
Maryland 2	uld be filed valued by the filed of the filed of the file event, the file even	To Be C	17. Father's Name (First, Middle, Last) LAWRENCE WEAVER					s Name <i>(F</i> OSA	First, Middle, M BERT	aiden Surnan	ne)	
	and 2 shou saith and N 27 Is mai		19a. Informant's Name/Relationship (Type. Print) TIMOTHY WEAVER/BROTHE		o. Mailing	Address (Street a EAST RIGO	and Number GS DRI	or Rural F VE L	Route Number, ANDOVER	City or Town, MARYL.	State, Zij AND	o Code) 20785
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked othe any injury or other traumatic event, once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	ORY 7	Date 2 / 6 / 2 (007 R	own, State ARYLAND					
Bal	permit Depar Impor any in	1 %	21. Signature of Funeral Service Licensed	4	1	Name and Addres	OOVER	ROAD	LANDOV	ER,MAR	YLANI	20785
	Physician		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	hat caused the death. Do non each line.		h	g, such as c	ardiac or r	espiratory arre	st,		Approximate Interval Between Onset and Death
	/Medical Examiner	<u>.</u>	Sequentially list conditions b.	e to (or as a consequence e to (or as a consequence			2					
8760,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events c.	e to (or as a consequence								
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy age 2 should be detached for use as the	sician/Me	in the past 12 months?	s, outcome pf pregnancy Live birth 2 □ Fetal death Pregnant at time of death Jnknown		Ectopic pregnancy Other (specify)					te of deliventh	ery Day Year
	quires that n signed by uld be deta	d by Phys	Part II. Other significant conditions contributing	to death but not resulting in	n the un	derlying cause give	en in Part I.		23e. Did tob 1 ☐ Ye			the cause of death?
Vital Records,		Completed							24a. Was an autopsy perform 1∐ Yes 2	/ led?	Were autoprior to codeath?	opsy findings available ompletion of cause of 2 PNo
r Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Ou	utpatient	3 DOA Othe	r-		Check only one 5 Reside		er (Speci	fy)
Division or	Attending Phradens r death. ector: After the by the funeral	ation: T	1 Natural 5 Pending 2 Accident investigation		Time of Injury	28c. Injury Work M 1 □ \	rat ⟨? Yes 2 □ N	ŀ	d. Describe ho	w injury occur	red	
Divis	i Dife	Certification:	3 Suicide 6 Could not be determined 28e.	Place of injury - At home, fa building, etc. (Specify)	arm, stre	et, factory, office		28f	Location (Str City or Town	eet and Numb State)	er or Rur	al Route Number,
	e Hospital 24 hours e e Funeral letely filled	Medical	29a. Certifier 1 Check only one) 1 Certifying Physician: T 2 Medical Examiner: On and	the basis of examination ar	nd/or inv	restigation, in my o _l	pinion, death	h occurred	at the time, da	ate and place,	and due	to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	1.		29c. License	number		29	d. Date signe	d (Month	Day, Year)
0	(3)		30. Name and address of person who completed	cause of death (Item 23a)	(Type, F	Print)	0. 1	<u></u>	+1100	June	51	20 - 10 - 1
	Sta	ite	31. Date filed (Month, Day, Year)	cause of death (Item 23a)	Liv	lingstrh	<i>iconc</i>	, , , ~	- WAY	141 ALA	1.	mylms
	Registr	ar	JUL 0 6 2007 Baren	1. 10.	-							

DHMH 17 Rev 1/2001

						Cei	tificate o		and Me	Re	g. No.	72	344)
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niner				street and numb E [†] S HOS]				- C	WII, OF LOCA			E GEORO	GE'S
	5. Social Secu		6. Se		Age (In yrs.	last birthday)	If Under 1 Yea		24 Hrs. 8	Date of Birth (Month, Day,	Vear)	9. Birthplace	(State or Foreign
	577-74	-0323	10	∄M 2□F	52	Yrs.	Months Day	S Hours	Non.	ARCH 6	1955	WASHIN	GTON, DC
	Usual Reside	nce of Decedent 10b. Cou			10c. City	y, Town or Lo	cation					10d. li	nside City Limits
by Funeral Director	MD		•	EORGE'S			PPER MAI	RLBORO				i	Yes 2 □ No
	10e. Street ar	d Number					10f. Zip Code			1	Og. Citizen of V	Vhat Country?	
	1150	7 BENNI	NGTON	DRIVE			2074				U.S.		
	11. Marital St			12. Was Deced Armed Force	es?	S. 13.	Was Decedent of f Yes, specify Co	f Hispanic Or uban, Mexica	igin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)	14. Race Blac	e - American Ir k, White, etc.	
		Married 2 ₪ N ved 4 🗗 Divor		1 ☐ Yes 2 If Yes, Give Year or Dat			1□Yes 2□N	o Specify:			Specify	AFRIC.	
ŀ		15. Dece	dent's Edu	ucation		16a. Dece	tent's Usual Occ	upation	t of working		16b. Kind of Bu		
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		ame (First, Mide	dle, Last)					18. Moth	JUNE	WILSO		16/	
	UNKNO	W'™ nt's Name/Relati	ionship (T	vpe, Print)		19b. Maili	ng Address (Stre	et and Numb				State, Zip Cod	(e)
				DAUGHTE	R		18th S'					0018	
	20a. Method		o 🗆 r	Damaual from Ci	C	Place of Dispo	sition (Name of natory or other p	olace)		Date	20c. Location -	City or Town,	State
		tion 5 Othe		Removal from St	LI		CEMETER			30/07	SUITLAN		
	21. Signature	of Fyrneral Serv	rice Licens	ee /	11		2. Name and Add				KINS FU		номе 0785
	Pok	· D.	17-	lications that cause on ear	/								proximate
aminer	Sequentially	list conditions,	5	b. Hy	oten c w	or as a consector as a consector (,	~					
	Sequentially if any, leadin cause. Enter Cause (Disea that initiated resulting in d	underrying ise or injury events eath) Last	J	d	Due to (o	r as e consec	uence of):						
	resulting in d	eath) Last	ditions co	d				given in Part	I.	23b. Did to	becco use co	ntribute to the	cause of death?
	resulting in d	eath) Last		d ntributing to dea	th but not res			given in Part	1.		obecco use con es 2□ No	ntribute to the	
ay in yaloldinin	resulting in d	eath) Last		d ntributing to dea NUU YW C U U	th but not res			given in Part	l.		es 2 No	3 Probabl 24b. Were a availab	uttopsy findings le prior to stion of cause
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Be Completed by Physician/M	Part It. Other 25. Was case examiner 1 Yes 27. Mapper of 1 Maturu 2 Accid 3 Suic 4 Hom 29a. Certifier (Check one) 29b. Signatur	significent conditions of the following search Last significent conditions of the following search last significan	dical dical dical dical dical dical dical dical dical dical dical dical examined	Hospital: 16 In 28a. Date of Month 28e. Place of building	patient 2 Injury Day Year) of tnjury - At high gets of examina or stated.	ER/Outpatie 28b. Time of Injury ome, farm, st	nderlying cause nt 3 DOA f 28c. Ir M 1 reet, factory, office vestigation, in m 29c. Lice	26. Plac Other: 4 N Injury at Vork? Yes 2 Cee	e of Death lursing Home 28	24a. Was a perform 1 1 Y Check only or e 5 Residud. Describe hold to the condition of the c	n autopsymed? 2 No n autopsymed? 2 No ne) nece 6 Oth ow injury occur treet and Numb n, State) ause(s) and ma ate and place,	3 Probabl 24b. Were a availat comple of deat 1 Ye er (Specify) red per or Rural Ro	tutopsy findings le prior to touse h? s 2 No nute Number, cause(s)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** 40 M 2007 July 1 ALTON J. WARD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Shady Grove Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Months 1☐M 2□ F Delaware Oct.8,1921 Director 85 222-05-9132 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 10a State 10h County 1 XYes 2 ☐ No Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 U.S.A. 'natural", or items 23a dical Examiner must b 5 Deer Park Lane Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 X If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black δ 3 PWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Farming 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Mary Daisey Ward Joshua ం 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2::
Department of Health a:
Important: If item 27 Is
any Injury or other trau Angelia R. Mumford-Daughter 5 Deer Park Ln Gaithersburg, MD 20877 20b. Place of Disposition (Name of Stemetery, crematory of other place).
St. John 2nd Bapt Church Cem 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3€ Removal from State 4 Donation 5 Other (Specify)
21 Sign Te of Funeral Service Lious Millsboro, DE 7/7/07 22. Name and Address of Facility Snowlen Funeral Home, PA ne of Funeral Service Ligh 246 N. Washington St Rockville, MD20850 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypernatemia
Due tyler as a consequence of): **Physician** /Medical Examiner Renat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit D5C3 and Due to (or a a consequence of): Box 68760. attending physician for use as the buria Tact Linfletion Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) signed by the at d be detached for P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, <u>ک</u> 2 ☐ No 3 Probably 4 Donknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes □ No 24a, Was an page 2 s Knee Ampytetiza this certificate 1□ Yes spital or Attending Physician: Ti hours after death. Ineral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D53654 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Center Drive, Rockville, MD 20850 AO 440 31. Date filed (Month, Day, Year) gistrar's Signature State 05 2007 Registrar

			For State Registrar		State o	f Marylan		artment (rtificate				lental Hy	gien Reg. N			
			Decedent's Name	e (First, Middle, L	ast)							2. Date of De	eath	firm W		3. Time of Death
	Physici /Medic			Kath1	een Lo	ouise	White					Month	D:		Year 7	1:49 PM
	Examin	100	4a. Facility Name (I	f not institution, g	ve street and nu	mber)		4b. City, To		Location	of Death			,	of Death	
	11 U. 11 SELEC	*	Doctors Cor					Lanhai						rince	Georg	
- 1	Funeral Director		 Social Security N 173-40-8699 		Sex 1□M 2ሺF	7. Age (In yrs. 55	last birthday) Yrs.	If Under 1 Months [Days	If Under Hours	Min.	8. Date of Bit (Month, Da Sept 28,	rth a <i>y, Y</i> ea 195	1	9. Birthp Coun Michi	lace <i>(State or Foreign</i> try) gan
	р ,		Usual Residence of 10a. State			100 Cit	v. Town or Lo	nation							1	0d. Inside City Limits
	aryla shov	2		10b. County											1	1 □ Yes 2 🖄 No
	the M	Director	MD 10e. Street and Nur	Prince G	eorges	R	iverdale	10f. Zip C	a da				100.0	itizan of l	What Coun	
	with a or	ă	5730 Cresty						737					ted S		uy:
U	ns 23 mus	Funeral	11. Marital Status	wood Tlace	12. Was Deci	edent Ever in U	.S. 13.			panic Or	igin? (Spe	ecify Yes or No Rican, etc.)			e - Americ	an Indian,
1036 3036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur		ied 2 ☐ Married	Armed Fo 1 ☐ Yes if Yes, Giv Year or D	2ሺ No ve		lf Yes, specify 1 □ Yes 2僅	-	i, Mexica Specify:		Rican, etc.)		Specify	ck, White, v: wh:	etc. ite
21215-0036	2 hou atura cal E	ted		15. Decedent's I	Education		16a. Dece	dent's Usual (Occupat	tion			16b.	Kind of B	usiness/Ind	dustry
- 215	within 72 iene. than "n he Medi	Completed	(Speci Elementary/Seco	oify only highest g	rade completed) College (1-4or 5+)	(Give	kind of work DO NOT use	done du retired)	uring mos	st of worki	ng	Ŧ	Kind of Business/Industry		
	ed wit rgien er tha t, the	S	,			+	Accou	ntant							Govern	ment ——————
Loor	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)									ne)				
Zo ya	should ind Men i marke umatic	ဥ	Ozelle White Nancy L. Frank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Townson)													
Mar	d2sh chand 7 Isn traun			•											State, Zip	Code)
-	1 and Health tem 27 other tr		Nancy L. White, mother 5730 Crestwood Place, Riverdale, MD 20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City											· City or To	wn, State	
47.6 7101	Pages nent of int: If it		1 □ Burial 2	ÖCremation 3 5 ☐ Other (Spec		State	emetery, crei Lincolr			1	7/7/20	007		twood	•	
ΚΑΤΗLEE Baltimore,	permit. F Departme Importan any Injur		21. Signature of Fu		-/_ /	110.			-			s-Rinald			′	Inc.
-√ m	permi Depa Impoi any Ir once,		1	aly to	hthu	ث	11	.800 New	Hamp	shire	e Ave.	, Silver	Spr	ing,	MD 209	04
8			23a. Part1 Enter to shook, or hea	he disea e, or co	mplications that o	caused the deat	h. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory a	arrest,			Approximate Interval Between
	Physician	8 9	Immediate Cause ((Final)		Imon									9	Onset and Death
	/Medical Examiner		resulting in death)	4	Due to	(or as a conseq										
B	Lxammer	_	Sequentially list co	nditions,		mmob	rlity									1-2 wks. Many yrs.
	ted nsit	nin	Sequentially list contains to his cause. Enter Under Cause (Disease or that initiated events	erlying				10000	, ,						1	7000 400
,	icate be executed physician and the burial-transit	Examiner	Due to (or as a consequence of):										7447 7.2.			
68760,	e be o	dical	d													
	tificat ig ph) as th	ledi														
Вох	death certifi e attending d for use as	an/N	IF FEMALE: 23b. Was deceden		23c. If yes, out 1□Live b	tcome pf pregna pirth 2 ☐ Feta	ancy Il death 3]Ectopic preg	inancv						te of delive	•
		Physician/Me	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	≥ No	4□Pregr 9□Unkn	nant at time of c	leath 5	Other (spec						Mic	onth	Day Year
P.0	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detache	Phy	Part II. Other signif		contributing to de	eath but not res	ulting in the u	 nderlying cau	se giver	n in Part I	l.	23e. Did	tobacco	use cont	tribute to th	ne cause of death?
Division or Vital Records,	uires sign Id be	d by	Breas	st Can	cer.	Obesi	ty,	Sleep	> /	4 pm	e 9.	10	Yes	2□ No	3 ☐ Prob	abiy 4 Unknown
Ö	w red	lete	HVDat	hyroid	i Can	Seve-e	A	theix	155	-		24a. Was	an	24b.	Were auto	psy findings available
æ	The lay te has age 2	Completed		lar I				,,,,					opsy ormed? 2 □ N		death2	psy findings available mpletion of cause of 2 No
ita	sician: Th certificate rector, pag	Be C	25. Was case refer		MES	Artista I			52	26. Place	e of Death	1 Yes		10	I-LI I ES	2 110
- >	Physic this ce	To E	examiner? 1 ☐ Yes 2 ☐	No	Hospital: 1 📑	Inpatient 2	ER/Outpatier	t 3□DOA	Other	r: 4□ Nt	ursing Ho	me 5□Res	idence	6 □Oth	ner (Specif	y)
Ē	ding P		27. Manner of Deat 1 ☐ Natural	h 5 🗌 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		: Injury Work?			28d. Describe	how inj	ury occur	red	
sio	tend leath. tor: / the fu	cati	2 ☐ Accident 3 ☐ Suicide	investigati 6 ☐ Could not		of injury - At he	ama farm atr	M		es 2 🗌		201 1	(0)	(4)		10 4 4/
N	lor A after d Direc	Certification:	4 Homicide	determine	buildi	ing, etc. (Specif	y)	eet, lactory, c	MICE			City or To	wn, Sta	te)	er or mura	l Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier	1 Certifying F	hysician: To the	e best of my kno	wledge, deat	n occurred at	the time	e, date a	nd place,	and due to the	e cause(s) and ma	anner as s	tated.
	ne Ho n 24 h ne Fu otetely	Medical	(Check only one)	2 ☐ Medicai Exa	aminer: On the b	asis of examina ner stated.	ation and/or in	vestigation, ir	n my op	inion, de	ath occur	ed at the time	, date a	nd place,	and due to	the cause(s)
	To the To the Comp	ž	29b. Signature and	title of certifier	-1					number			29d. D	- /	/	Day, Year)
	7		SI	XF	J.M.					3/0					21/2	
	1		Stuart	ress of person with	eritz	se of death (item	n 23a) (Type,	Print) 75	-00 ree	16	een	MD	Cat	r. 0	r. #	-430
	Sta Registr	_	31. Date filed (Mon		2007 32.5	Mistrar's Signa	atury 14	port		,				-		

			- FOI	epartment of Health and I Certificate of Death		ene g. No.	
r	Physicia	an l	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Melvin James Yerby Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	06-25-20	4c. County of Death	7:46 A M
	Examin	er	Southern Maryland Hospital	Clinton		Prince Geo	rge
•	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	The state of the s	8. Date of Birth (Month, Day,	Year) 9. Birth	olace (State or Foreign ntry)
	Director		231-50-8500	15.	12/13/19	39 Fair <u>r</u>	ort, VA
	ryland how		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	he Ma 8a-f s otified	Director		ngton DC	10	g. Citizen of What Cou	1 Yes 2 No
	a or 3		3416 Brothers Place S.E.	10f. Zip Code 20032		USA	nuy:
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
20	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other than "natural" or Items 23a or 28a-f show If item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Tes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1962	1 ☐ Yes 2 No Specify:	,	Specify: Blad	
5	2 hour		15 Decedent's Education 16a.	Decedent's Usual Occupation	tion 1	6b. Kind of Business/Ir	
713	within 7, iene. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	1	. 1 0-	
7	filed within Hygiene. other than "		12 Mai	chinist 18. Mother's Nar	ne (First, Middle, M	ed. Governm Maiden Surname)	ent
<u> </u>	ould be filed Mental Hygi arked other atic event, t	To Be	Llyod Yerby		Jackson		
ary	2 should I and Men Is marker aumatic			Mailing Address (Street and Number or Ru	ıral Route Number,		c Code)
≦ 2)	1 and 2 Health tem 27 I			4 Dundalk Dr. Oxon		20745 20c. Location - City or T	own State
	Pages nent of h int: If ite		1 1 R Burial 2 Cremation 3 Removal from State	Disposition (Name of y, crematory or other place) Hill Cemetery 07/02		uitland, MI	
allillo	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of FacilityCed	lar Hill	uitiand, Mi Funeral Hom)
0			May Tedgman MO1374	4111 Pennsylvania A	ve. Suit	land, MD 20	746
	1 7 - 34		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ot enter the mode of dying, such as cardia	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or s a consequence of the consequen	dial intarc	tion	,	
	Examiner		Sequentially list conditions b. Atteros	clerotic God	OVOSCO	lov Dise	ise
	red isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	n):			
<u>,</u>	execui n and ial-trar	Examin	that initiated events ' c Due to (or as a consequence of	of):		-	
09/90	ficate be executed physician and s the burial-transit	edical	C d				
			IF FEMALE: 23c. If yes, outcome pf pregnancy			22d Date of deliv	
Ď D	siclan: The law requires that the death centi certificate has been signed by the attending rector, page 2 should be detached for use a	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	Day Year
,	at the oby the trached	hysi	9 ☐ Unknown		1		
Š,	law requires that the death as been signed by the atter 2 should be detached for u		Part II. Other significant conditions contributing to death but not resulting in		23e. Did tob	accoluse contribute to es 2 □ No 3 □ Pro	the cause of death?
ecords,	v requi	eted	11 2016 01 01 01	Court	24a. Was ar		opsy findings available
ě	The lav	Completed by	Type Tension		autops: perforn	y prior to or death?	ompletion of cause of
VIII I	lan: ertificat	Be C	25. Was case referred to medical examiner?	26. Place of De	ath (Check only one		25.10
2	Physiclan: r this certific ral director,	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out		lome 5 ☐ Reside	nce 6 Other (Spec	ify)
	iding Phys h. After this funeral di	tion:		ime of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	260. Describe no	w injury occurred	
VISION	Attending or death.	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Sti	reet and Number or Rui n, State)	ral Route Number,
5	urs afte	Cert		doubt a source of at the time of the soul also			d
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) (Check o				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month	, Day, Year)
4			1 yes mo	P003+00	0 0	6-67-20	07
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 (88 0)	Kon Ita	MACH #	701
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signards.	ij okon	111/1	20	/ -
	Registr		I III II D CUUL Pia . 7. 2000				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Christopher T. Ammon

illistopher 1. A		State of Maryland / Department of P		Reg	. No.	
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death
ledical Exami	ner	Christopher Thomas Ammon		Month [July 18, 200)7'	1636 hrs
			City, Town, or Location of Deat	th	4c. County of Death Prince George	'e
			aurel	- lo B-1- (B-1)	(MM/DD/YYYY) 9. Birt	
Funeral			f Under 1 Year If Under 24Hr Months Days Hours Mir	n.	Foreig	n
Director		217-13-4616 1XM 2F 35 Yrs.	- 370 1.0010	Oct. 28	3, 1971 Cou	untry)Maryland
<i>x</i>	ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location				10d. Inside City Limits
w any		,				1 X Yes 2 No
Varyland 28a-f show d at once.	ō	MD Prince George's Laurel		10 1		A
Mary 28a-	Director	10e. Street and Number	0f. Zip Code	100	. Citizen of What Cour	itry?
215-0036 be filed within 72 hours after death with the Maryland and Hygiene other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once ont, the Medical Examiner.		14803 Bowie Road, #301	20707		USA	
h with	Funeral	4 15 0	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puert	Specify Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,
deatl or ite	'n	1 Yes 2X No		io raceni, cic.,		
after al", iner	ò	or Dates:	es 2 X No specify:		Specify: Wh	
hours natur		during most	Usual Occupation (Give kind of of working life. DO NOT use re		16b. Kind of Business/l	ndustry
16 n 72 ian "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			G	
003 withi jene.	E	7	uction Supervi	LSOT ne (First, Middle, Ma	General Co	ontracting
15-1 filed I Hyg d oth		17. Father's Name (First, Middle, Last)		Line Cia		
21215-0036 buld be filed within 7 Mental Hygiene. marked other than te event, the Medica	o Be	Philip Joseph Ammon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or			Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Despertment of Health and Mental Hygelment Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	ř		aurelwalk Driv			·
, MD and 2 sho lealth and tem 27 is		20a. Method of Disposition 20b. Place of Disposition			20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 XBurial 2 Cremation 3 Removal from State crematory or other	place)			
timent tant:		4 Donation 5 Other Specify: Gate of He	Silver Sp:			
Salt ermit Separt mpor njury			Funeral Ho			
		23a. Part Enter the disease, or complication, that caused the death. Do not enter the	, MD 2070	Approximate Interval		
Physician /Medical		failure List only one cause on each line.	st, Shock, or hour	Between Onset and Death		
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Deali
		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):				
	ᇤ	cause. Enter Underlying Cause (Disease or injury that initiated				
ed sit	Examiner	events resulting in death) Last Due to (or as a consequence of):				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		d				
O, be es siciar	Medical	X UNPENDED 445, 27, perME, g871, 9/26/C	7 TT			
760 ficate b g physic s the bu		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic pregr	nancv	23d. Date of delivery	/ Day Year
r 68 certi endin use as	cial	past 12 months?	· (Specify)	ilano,		
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	(oposity)		1	
that the d		Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
, P.O. res that the signed by be detach	Completed by			1 Yes	2 No 3 Prol	oably 4 🗸 Unknown
ds required rould	ete			24a. Was a		topsy findings available completion of cause of
COI s law e has e 2 st	mpl		-	autops perform	ned? death?	-
tal Rection: The certificate certificate			26 Diago of Dooth (Choo	1 Yes 2	No 1 Y	es 2 No
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient :	26.Place of Death (Chec		Residence 6 🗸 Othe	r: Scene
of Vid Physic er this	To	1 ✓ Yes 2 No			ow injury occurred	
ion of tending Pheath.	on:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury (Month, Day,Year)	1 Yes 2 No			
Sio Atten deati retor:	cati	Accident Investigation 28e. Place of Injury - At home, farm, street,		28f Location (C)	treet and Number or P	ral Route Number, City
Jivi d or z safter 1 Direct	Certification:	Suicide Could not be determined (Specific)	izactory, omice bunuing, etc.	or Town, St		ara. Noute Number, City
Ospit:		4 Homicide	at the time date and aller	nd due to the	v(e) and manner as state	ad
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: /	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	a at the time, date and place, ar n, in my opinion, death occurred	d at the time, date a	nd place, and due to the	e cause(s)
To 1 To 1	Ned	and manner stated. 29b. Signature and title of certifier	29c. License number	T	29d. Date signed (Mo	
	_		O.C.M.E.		July 19, 2007	
		Doma nu incatino	O.O.IVI.L.			
7		30. Name and address of person who completed cause of death (Item 23a)	onn Street Deltimore	MD 24204		
V			Penn Street, Baltimore,	IVID Z IZUI		
S Regis	tate trar	Profession and American State of the Control of the	K)			
		00118				
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07-05366

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Dennis Barnes Certificate of Death 1- For State 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day July 13, 2007 1217 hrs Physician/ Larvas Sarnes ∜ Examiner ennis 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Maryland General Hospital 8. Date of Birth(MM/DD/YYY) 9. Birthplace (State or If Under 24Hrs If Under 1 Year 7. Age (In yrs. last birthday) Social Security Number Foreign **Funeral** Hours Months Days Country) Jary/ans 213-76-033 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 No BAltimorre s 23a or 28a-f shore, MARYLAND 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number NORTH 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Yes Specify: ag Yes 2 No specify: Divorced If Yes, Give Year Widowed after 16b. Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) permit Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked injury or other during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Labore 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2// 37 19a. Informant's Name/Relationship (Type, inter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Langdowne Comete 7 ZIOK Donation 5 Other Specify. Harris Funeral Home 21. Signature of Funeral Service Licensee 2. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or huard Approximate interval Between Onset and **Physician** failure. List only one cause on each line Death Cocaine and heroin intoxication Medical Immediate Cause (Final disease xaminer_ or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical X UNPENDED 4#2925,27,28a-f, perME,g869, 7/25/07 TT attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, IF FEMALE: 23b. Was decedent pregnant in the Year Day 2 Fetal death Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of certificate has been autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death 25. Was case referred to medical Division of Vital Be Hospital: 1 Other 4 Nursing Home 5 Residence 6 examiner? DOA Inpatient 2 V ER/Outpatient 3 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Yes 2 X No Natural Pending Fnd 11:30 am Director: d in by the f FNd 7/13/2007 28f. Location (Street and Number or Rural Route Number, City Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 6 X Could not be 3 1919 McCulloh St. Baltimore, MD Suicide (Specify) abandoned house Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 14, 2007 O.C.M.E. 30. Name and address of person who completed wuse of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month,

OCME

ORIGINAL

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State of Maryland	-			ental Hyg	jiene		
		Registrar 1. Decedent's Name (First, Middle, Last)	Cei	tificate of D	eath	2. Date of Dea	leg. No.	4-1-	3. Time of Death
Physici	an					Month	Day	Year	. M
/Medic		John Blanchard Bowman, J 4a. Facility Name (If not institution, give street and number)	r.	4b. City, Town, or L		July	18 4c. Cou	2007 nty of Death	3:40P [™]
Examin	ler	Carroll Hospice Dove House		Wes	tminster			Carrol	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1		lace (State or Foreign
Director		215-46-5235 ^{1™ 2□ F} 58	Yrs.	Months Buyo	110010	Aug. 1	1, 194	8 Mary	land
and t		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation				1	0d. Inside City Limits
Mary f sho	힏	Maryland Carroll		Taney	town				1XXYes 2 ∐ No
r 28a	Director	10e. Street and Number		10f. Zip Code	LOWIT		10g. Citizen	of What Coun	try?
th with	a D	113 Morning Frost Street			21787			U.S.A.	
ems er mu	Funeral [11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe	cify Yes or No- Rican, etc.)		lace - America	
s afte	by Fu	1 ☐ Never Married 2★ Married 1 ☑ Yes 2 ☐ No If Yes, Give		I□Yes 2⊠No	Specify:	, ,	Spe	cify:	
hour tural' al Ex	q pe	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1 969-		lent's Usual Occupat	tion		16h Kind of	Business/Inc	hite
in 72 n "na Aedic	Completed	(Specify only highest grade completed)	(Give	kind of work done du OO NOT use retired)		ng	, , , , , , , , , , , , , , , , , , , ,	2401100071110	addily
d with giene ir tha the h	mo.	Elementary/Secondary (0-12) College (1-4or 5+) 12		Parts_cle	rk		tru	ck cen	ter
al Hyg l othe vent,	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Surr	ame)	
Ment Ment arked arlc e	P	John Blanchard Bowman Sr.			Mary	y Grime:	5		_
2 short and rismand raum	1.0	19a. Informant's Name/Relationship (Type. Print)		g Address (Street ar					
1 and Health Sm 27 ther t		Sandra Faye Bowman/wife 20a. Method of Disposition 20b. Pl		Morning F sition (Name of		Tane		MD 21 n - City or To	
ages nt of l		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, crer	natory or other place	- 100			•	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.		4 □ Donation 5 □ Other (Specify) Mic	ddlebu / 22	rg Cemeter Name and Address	ry 7/23/	-1-p F	Midale	eburg,	עש
permi Depar Impor any ir		ofharine V. Xlar Bler	6	E. Broadv		on Brid			ı
VERM		23a. Part1. Enter the disease, or complications that c d the death shock, or heart failure. List only one cause on each line.					•	2175	Approximate Interval Between
Physician			cree	+, 6	i. L C e n				Onset and Death
/Medical		resulting in death) Due to (or as a consequ			N' N' C C.				
Examiner	L.	Sequentially list conditions, b.							
led Isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ience or):					0	
cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last c Due to (or as a consequ	uence of):						
e be e sicial	dical	d							
							1		
th cer tendin r use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant Light the cost 12 proof to 2 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal		Ectopic pregnancy				Date of delive	•
e dea he att	sici	1 Yes 2 No 4 Pregnant at time of de		Other (specify)				Month	Day Year
hat th d by t letach	Phy	9 ☐ Unknown	ulting in the ur	nderlying cause giver	in Part I	23e Did to	hacco use o	ontribute to th	e cause of death?
signe signe	ą	Nane Krowh	atting in the di	idenying oddoe giver	THIT CITY.	1 □ Y			
v requ	etec	// 3		1 10		24a. Was a	10000 1 7 7 7		~
he lav e has ge 2 :	Completed					autop perfor	sy med?		psy findings available npletion of cause of
ificate or, pa	e Co	25. Was case referred to medical			26. Place of Death	1□ Yes	2 X No	1 ☐ Yes	2 □ No
ysicia s cert direct	To B	examiner?	ER/Outpatien	Othor				Other (Specifi	Inputient
ig Phy ter thi		27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury Work?	at 2	28d. Describe h			Mospiece.
endin ath. or: Af he fur	atio	2 ☐ Accident investigation	,,		es 2□No				
or Att ter de lirectu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hombuilding, etc. (Specify	me, farm, str	eet, factory, office	2	28f. Location (S City or Tow	treet and Nu n, State)	mber or Rura	l Route Number,
pital ours af		Continue Physician To the heat of my lens	udadaa daati	2 COOURSed at the time	a data and alasa				
To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) (Check one) (Check only o							
Fo the within Fo the Sompl	Me	29b. Signature and title of certifier		29c. License				ned (Month,	
0		I found front m.D.	,	2 /	5552		7/	20/07	•
4		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)					
. 0				att (e	nten St	Wa.	stmin.	ゲイク	md. 21157
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signat		2000					
MU 17 Day 1/0		JUL 2 3 2007 July 1	O A						

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAYNEW

- HOPMAS

31. Date filed (Month, Day, Year)

			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings availing prior to completion of cause death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Dea	ath (Check only one)
examiner? 1 ☐ Yes 2 ☐ Ho	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		t, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
			e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
20h Signature and title of certifier		29c. License number	29d Date signed (Month Day Year)

Year

2007

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐Yes 2 No

MARYLAND

State Registrar

Medical

DHMH 17 Rev 1/2001

MFDICAL

32. Registrar's Signature

TEP, MANO Eastern

	•	For State Registrar	State of	Marylan	-	rtment of tificate of		nd Mer		ene J. No.	J J T	231	113
Physici		1. Decedent's Name (First, Middle, Last) Elizabeth Daws	on Bi	eker					Date of Death Month	2 ^{Day}	20′0″	3. Time of 6:40	Death A M
/Medic Examin	~ 40	4a. Facility Name (If not institution, give s Gilchrist Center	street and numi	ber)		4b. City, Town	or Location of I Towson	Death		4c. Coun	ty of Death Balt	imore	
Funeral Director		5. Social Security Number 6. Security 15-14-2147	7] М 2[X] F	. Age (In yrs. I	last birthday) 4 Yrs.	If Under 1 Year Months Day		4 Hrs. 8. Min. 0	Date of Birth Month, Day, 5	23	Cou	place (State o	r Foreign
D	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Balt	imore	10c. City	y, Town or Lo							10d. Inside Ci 1 ☐ Yes	
with the 3a or 28a st be noti	Il Direc	10e. Street and Number 28 Allegheny Aven	ue Apt	1807		10f. Zip Code 212			100	g. Citizen o	f What Cou	•	
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 29a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	ces? 2 🔀 No	1	Vas Decedent of Yes, specify Co	uban, Mexican, i	in? (Specify Puerto Ric	y Yes or No- an, etc.)		ace - Americack, White,		
within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	lent's Usual Occ kind of work dor OO NOT use reti Keeper	ne durina most d	of working			Business/In	dustry Compai	าy			
ld be filed lental Hygi ked other Ic event, ti	To Be Co	17. Father's Name (First, Middle, Last) Roy R. Dawson	1	ther's Name (First, Middle, Maiden Surname) Virginia Woody									
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Ty David L. Dawson		er	1	g Address <i>(Stre</i> Melros			adys, V	-		Code)		
		20a. Method of Disposition 1 【X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		tata C	emetery, crer	sition (Name of natory or other p Cemete		Date 7/24/	2007 F	20c. Location - City or Town, Sta Parkville, Mary			ınd
permit. Departinorts any inj	k Å	21. Sign Mar of Funeral S-rvice Mars	nes of	<u> </u>	L	. Name and Add eonard	J. Ruck	, Inc	. Balt	imore	ford R e, MD	21214	
Physician /Medical Examiner the burial-fransit	dical Examiner	23a. Part1. Enter the deease, or compl shock, or heart failure. List only o immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	or as a consequence as	uence of):	ncu.	ying, sour as o	ardiac of the	espiratory arres			Approximatinterval Bet Onset and	ween Death
w requires that the death certific been signed by the attending p should be detached for use as i	Physician/Mec	iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown		rth 2 ☐ Feta ant at time of d	aldeath 3	Ectopic pregna Other (specify)					Date of delive	,	Year
juires that in signed by ald be deta	by	Part II. Other significant conditions co	ntributing to dea	ath but not res	ulting in the u	nderlying cause	given in Part I.		23e. Did toba			the cause of o	
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as: Medical Certification: To Be Completed by Physician/Mec	Complete								24a. Was an autopsy perform 1 Yes 2		b. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings ompletion of c	available ause of
	25. Was case referred to medical examiner? 1 Ves 200No												
Hospital c 24 hours af Funeral D tely filled in	edical Cer										manner as ce, and due	stated. to the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of certifler	and mann	or stated.		29c. Lice	ense number	3	29	d. Date sig	ned (Month	, Day, Year)	,
H str	ate	30. Name and address of person who c	MALE	of death (Item	m 23a) (Type,	Print) 701 No	Charl	us J	1- 100	VSUN	mo	zno	y
Regist	rar	JUL 2 3	2007	Francis I	Mr. A	DEALL !							

Elizabeth Breker July 21, 200, Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** Caroline Frances **Bullock** 10.45 AM 7 /Medical 4a. Facility Name (If not institution, give street and number), 4c. County of Death 4b. City, Town, or Location of Death Examiner Ball-none Sumaritan Good MOSPILX N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 🛛 F Mary land 219-21-6609 78 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notifiled at once. 10c. City, Town or Location 10d. Inside City Limits N/A 1 X Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 Frankford Avenue Apt#117 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 5 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Aubrey Bullock Caroline Neuner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. Platek - Nephew 928 Litchfield Road Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 07/23/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Foneral Service License 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lisy only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mracran **Physician** /Medical Due to (or as a consequence of): Examiner Suprisherpeut Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♠ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed? certificate 1 🗌 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No 1 Plnpatient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Fo the Hospital or Attending Physician: in 24 hours are:
the Funeral Director: Af

Baltimore, Maryland 21215-0036

29a. Certifier 1 🚱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7/19/.7 MD 202

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:17 AM Edwin Brown, Sr. 18 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□ F 220-14-9392 82 Director 03/02/1925 Maryland Usual Residence of Decedent 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits must be notified at MD? N/A Baltimore 1√2K/es 2∐No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3105 Royston Ave. 21214 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give WW I 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hygiene. wher than "natural", or Item ent, the Medical Examiner I Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify: White Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 8 and Mental Hygi is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lewis Brown Helena Wilhelmina Stoltea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Earl E. Brown, Jr. / item 27 i 3105 Royston Ave. Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 7/21/2007 Parkwood Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Rd. kimber ly Davidson Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VALVE REPLACEMEN 3☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No spital or Attendiours after death.
neral Director: / 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

03/02

DHMH 17 Rev 1/2001

Registrar

Medical

29a. Certifier (Check only one)

and manner stated.

32 Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

5601 LOCH RAVEN BLVD, BALTIMORE, MD, 21239

29d. Date signed (Month, Day, Year)

				State o	f Marylai		partme <i>ertifica</i>		lealth and l Death		giene Reg. No.	11	23451	
	Physicia		Decedent's Name (First, Middle, Le HELEN MAE BR	st) YAN						2. Date of De Month July	Dey	Year 007	3. Time of Death 1:15 PM	
N	/Medica Examine		4a Facility Neme (If not institution, giv		mber)			4	lb. City, Town, or					_
1	Examinite.	31	Brooke Grove Nur		,	litati	ion Ce	enter	Sandy S	Spring	Monto	omer	7	
	Funeral		Social Security Number 6. 8		7. Age (In yrs		lay) If Unc	ier 1 Year	If Under 24 Hrs			9. Birthpl	ace (State or Foreig	n
	Director		217-32-0327	I□M 2∏ F	8	88 Yrs	Month.	s Days	Hours Min.	Aug. 2	4, 1918	Count Mary		
			Usual Residence of Decedent											
	ylan		10a. State 10b. County		10c. C	ity, Town o	r Location					10	d. Inside City Limits	
	Marie Marie	혓	MD Howard		I	Laure	L						1 □ Yes XXNo)
	or 28	je j	10e. Street end Number				101. 2	Zip Code			10g. Citizen of V	Vhat Count	ry?	
	23a (<u>=</u>	9845 Lyon Avenue					207	723		Ţ	JSA		
	dead	Funeral Director	11. Merital Status		edent Ever in U	J,S. 1	13. Was Dec	edent of H	ispanic Origin? (S In, Mexicen, Puerl	pecify Yes or No	- 14. Rac	e - America		
0	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Examinat must be notified at		1 Never Married 2 Married	1 Yes	21X No			2X No		o moan, etc.,				
9	ours	2	3XXWidowed 4 ☐ Divorced	Year or D	ates:		1 103	222110	opoury.		Эреспу	Whi		
21215-0020	72 h	Completed	15. Decedent's Education (Specify only highest gra	ducation		16a. De	ecedent's Us	sual Occupa	ation during most of world)	rkina	16b. Kind of Bu	usin <i>e</i> ss/Ind	ustry	
21	ithin	현	Elementary/Secondary (0-12)	College (1-4or 5+)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	e. DO NOT	use retired)					
	ygier re. #	ဂ္ဂ	7th	Ø		Ho	omemak	er				Home		
Maryland	d off	æ	17. Father's Name (First, Middle, Last,)						Name (First, Middle, Maiden Sumame)				
yla	Men Men arke	၉	Edward Penn							ence Phe				
Jar	2 sh and is m		19a. Informant's Name/Relationship (Type, Print)			-		and Number or Ru		er, City or Town,	State, Zip	Code)	
	and ealth n 27 rer ti		Shirley L. Burton	/Daught					ue, Laui		20723			
O.	or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from		cemetery,	sposition (A crematory o	r other plac	Θ)	Date	20c. Location -	City or Tov	vn, State	
Ē	Pag ment ant: lury c		4 ☐ Donation 5 ☐ Other (Specif			nion (Cemete	ery		7/20/07	Burtor	nsvil.	Le, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signeture of Funeral Service Licer	ss of Facility Do	onaldson	Funeral	L Home	e, P.A.						
Ш	20 = 20		hominos	t Avenue	e, Laure	1, MD 2	20707							
			23a. Part1 Enter the disease, or com shook, or heart failure. List only	plications that o	aused the dea	th. Do not	enter the m	ode of dyin	g, such as cardia	or respiratory a	rrest,	ĺ	Approximate Interval Between	
	Physician		shoot, or your raidre. Elst only	Ollo Jaase on C	aur inio.								Onset and Death	
	/Medical		Immediate Cause (Final disease or condition	Proc	umo	Kin						1	8 Hours	>
	Examiner		resulting in death)	a			sequence o	nf):				1		_
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	ficate be executed physician and as the burial-transit	Examiner	Sequentially list conditions,	b	Due to (or es a con	sequence o	rf):				1		
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	= D 0	8	Tooding in adda, Lad.									1		
Вох	death certific	Physician/M		d								1		
	the att	SC	Part II. Other significant conditions of	ontributing to de	eath but not res	sulting in th	e underlying	g cause give	en in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death	?
P.O.	at the by the stach	<u>ج</u>								1 🗆	Yes 2XNo	3 🗆 Prob	ably 4 ☐ Unknow	vn
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of Vital Records,	law requires that the death cert as been signed by the attendin 9 2 should be detached for use	<u>8</u>								24a. Was	an autopsy prmed?	ava	re autopsy findings ilable prior to	
ပ္မ	aw re Is be	Completed											pletion of cause eath?	
ď	The law ate has page 2	E								10	Yes 2 XNo	1□	Yes 2□ No	
ita	ysician: The list certificate hadirector, page	Re C	25. Was case referred to medical						26. Place of Dea	ath (Check only	one)			-
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0	5 E B	=	27. Manner of Death	28a. Date	of Injury	28b. Tim Injur		28c. Injun Worl			how injury occur			
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	s after in Dir	Sel	4 - Hollinda	Dalla	11g, 6to. (<i>Opeo</i>	•97				Only or vo	, 5.2.67			
	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune		29a. Certifier 1 Certifying Ph											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edica	(Check only 2 Medical Exen		ner stated.	autori driu/O				med et die dille,				
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	-			-	9c. License		29d. Date signed (Month, Day, Yeer)				
			L Choux	CM S			1	233	100		July 1	8,2	007	
	17		30. Name end address of person who	completed caus	e of death (Ite	m 23a) (Ty								
	5		IEDHOWE 15	1 N.A	RTIZA	NST	. N	ILLIF	AMSPOR	J. MI	2	1795		
	State		31. Date filed (Month, Day, Year)	32. R	egistrar's Sign	ature	mark)							

DHMH 16 Rev 6/95

	Phy /M Exa	d
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 2 should be detached for use as the burish-transit
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	•	For State Registrar		Otate	OI WIA	i yiai i		tificate of I		Wiemanny	Reg. No.	1 1 1	00110
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Physicia /Medic		DONNA			M						19	2007	4:45 A M
Examin _		4a. Facility Name (i 4000 FA 5. Social Security N	LLSTAFF	ROAD AF	PT. 2		ast birthday)	4b. City, Town, or BALTIMO If Under 1 Year				N/A	place (State or Foreign
Funeral Director		239-96-	4792	1 M 2 F		52	Yrs.	Months Days	Hours Mir		ay, Year)	ÜNKNOWN	
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re filed within 72 hours after death with the Maryland al Hygiene. • I other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notified at	ρ	1 Never Mari 3 Widowed			Forces? s 2 No Give X Dates:	o		Yes, specify Cuba	Specify:	rto Rican, etc.)	Spec	lack, White, c <i>ify:</i>	WHITE
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permit Depart Import any inj		Roc	5/	Two		\geq							MD 21208
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition											Approximate Interval Between Onset and Death	
be executed sician and burial-transit	al Examiner	Sequentially list conditions, fany, leading to immediate course. Finds the design of the course of injury hat initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):											
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w requires that been signed to should be det		Part II. Other signi	ificant conditio	ns contributing to	death but	t not resu	ilting in the ur	iderlying cause giv	en in Part I.		tobacco use co		the cause of death?
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ul or Attending Physician: after death. I Director: After this certifice d in by the funeral director, p	Certification:	Natural Accident Suicide Homicide	5 ☐ Pending investig 6 ☐ Could n determi	ation ot be 28e. Pla	onth, Day ace of injuriding, etc.	ry - At ho	Injury me, farm, stre		K? Yes 2 □ No		(Street and Nur wn, State)	mber or Rur	al Route Number,
Hospita 4 hours Funera (ely fille	Medical Ce	29a. Certifier (Check only one)	i Certifyîn 2 Medical I	Examiner: On the	the best of basis of e anner state	examinat	wledge, death tion and/or inv	occurred at the tire restigation, in my co	ne, date and pla pinion, death oc	ce, and due to the	e cause(s) and , date and plac	manner as	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and	title of certifier		m.	\supset		29c. Licens	e number		29d. Date sign		
10	-	30. Name and add	ress of person	who completed ca			23a) (Type	Print)	, ()		-7	19/57	'
4		Willia	.~ 5	hartm	نور	10	753	Print) Fall Rd	サリント	Limen	11e M	9 5	1093
Sta Registr		31. Date filed (Mor	10 Lay, 20 a 3	2007	Registrar	r's Signal	ture						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend #30, perDVR, g869, 7/23/07 TICertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician The 1ma Viola Cockey July 21, 2007 11:05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Hospice Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 214-20-0677 Director 19, 1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be nottlied at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7532 Dogwood Road 21784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ♣ No Specify Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant 12 Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Laabes ပ Viola Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty A. Cockey Daughter-in-law 7532 Dogwood Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or 7-26-07 Lake View Mem. Park 4 Donation 5 Dother (Specify) Sykesville, MD 21. Signature of Funer 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** evere disease or condition resulting in death) /Medical o (or as a consequence of): Examiner 0 Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Insufficiens bunial-tran to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hou Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Mother (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours after deatl **Fo the Funeral Director**:

State

4 Homicide

29a. Certifier (Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D22663 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nagji J. Sureja, MD Dove House Hospice, Westminster, MD

31. Date filed (Month, Day, Year) JUL

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 HISA Mabel Jennette Chenoweth 101 201 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dove House (moll Mestmins If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M **XX**F Months Days Year Hours Yrs 220-05-0765 88 Jan. 1919 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County XXYes 2 No Maryland Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7200 Third Avenue, Apt. U409 21784 America Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married 1 ☐ Yes XX No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Manager Mortgage Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Charles Shoul Mabel Ray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21784 19a. Informant's Name/Relationship (Type. Print) Harry Marvin Chenoweth (Husband) 7200 Third Avenue, Apt. U409; Sykesville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State July 24. Burial 2 Gremation 3 Removal from State Parkwood Cemetery 5 ☐ Other (Specify) 4 □Donation 2007 ALIDORIANON Agnature of Fundamental Price Line And Campung Baltimore, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road; Owings Mills, MD 21117 . Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im red te Cause (Final disease or condition Preumonia DOYS resulting in death) Due to (or as a consequence of) hronic obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2. No 1∏ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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7 Is marked other than "natul traumatic event, the M. dical

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Department of Health at
Important: If item 27 Is
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Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

and signed by the a certificate has birector, page 2 s director, funeral After within 24 hours after death

To the Funeral Director:
completely filled in by the

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Hospital or Attending Physician:

Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant þ Completed Be 25. Was case referred to medical examiner? 1 Yes 2 No ٩ 1 Inpatient 28a. Date of Injury 27. Manper of Death Certification: 1 Natural (Month, Day Year) 5 Pending investigation 2 Accident Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

🔟 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29a. Certifier

29c. License number 00059943 29d. Date signed (Month, Day, Year) 20,200,

1 nostient

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

295 MORI MO 31. Date filed (Month, Day, Year)

State Registrar

Medical

32. Registrar's Signature

07-05497 Alexander N. Ches Physician Medical Examine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

xander N. Che		For State of Maryland / Department of Floath and Maryland / Department of Floath / Department of	Reg. No.
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Funeral	- 1	5. Social Security Number 6. Sex Months Days Hours Min.	rusy 9,1949 Country) Mary and
Director		2/3-52-260/ 1XM 2 F 38 Yrs. V30	10d. Inside City Limits
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Baltimore, permit. Pages la Department of He Important. If it injury or other t		4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charty	nax-Harn's Fureral Han Balt., MD 21206
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Box 68760, te death certificate be the attending physic and for use as the burned for use as the burned.	§	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Day Year
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S, P uires t n sign	Pa	Seizure disorder, end stage renal disease, diabetes mellitus,	24a. Was an 24b. Were autopsy findings availab prior to completion of cause of
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isio Atter	10 to	2 Accident Investigation 286. Place of Injury - At home, farm, street, factory, office building, etc. 28f.	Location (Street and Number or Rural Route Number, Ci or Town, State)
ital or ral Div	Cortification.	Suicide 6 12 Could not be determined (Specify) unk	
Division of Vital Records, P.O. E To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by til			to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
Fo the vithin To the	completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, which is a second and manner stated. 29c. License number	29d. Date signed (Month, Day, Year)
	~ \$	O.C.M.E.	July 18, 2007
		Muna Plasel M >	
8		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21.	201
2	Cha	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Red	Sta istr	JUL 2 3 2007 Blagen B.	

ORIGINAL

		1	For State Registrar	tate of Maryland			t of Health and e of Death		gienę Reg. No. 0 0 7	23455
	hysicia	ın	1. Decedent's Name (First, Middle, Last) William (65H	eY				2. Date of De Month	ath Day Year 18 200	3. Time of Death
Fu	/Medic xamin neral ector	er	4a. Facility Name (If not institution, give street) 5. Social Security Number 219-42-1690 4a. Facility Name (If not institution, give street) 6. Sex	et and number) +0 Sm + c Age (In yrs. I	ast birthday) Yrs.	4b City, If Under Months	r 1 Year If Under 24 Hrs	200 N 8. Date of Bir	4c. County of Dea	thplace (State or Foreign ountry)
aryland	i i		Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City	r, Town or Loc Ba1	ation	re			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ith the M	or zea-r	Director	10e. Street and Number	Ant E		10f. Zij	21244		10g. Citizen of What C	
offier death w	r nems kas	Funerai	1 Nover Married 2 Married	Was Decedent Ever in U. Armed Forces?	lf .	Yes, spe	dent of Hispanic Origin? (cify Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite, etc.
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.	edical Exar	Completed by	15. Decedent's Educati (Specify only highest grade co	mpleted)	16a. Decede	ent's Usu	al Occupation ork done during most of wise retired)	orking	16b. Kind of Business	lack Mindustry
d 212 filed withi Hygiene.	ont. the M	Ве Сотр	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Tr	ruck	Driver 18. Mother's Na	ame (First, Middle	Transpo , Maiden Sumame)	rtation
rylan hould be d Mental	marked matic ev	To B	Eldridge Costley 19a. Informant's Name/Relationship (Type,	Print)	19b. Mailine	a Addres	Jas (Street and Number or F		abeth Brigh	
and 2 si	m 27 is her traus		Ms. Teresa C. Costle	y (Daughter	1	Turr	about Lane)44
Baltimore, permit. Pages 1 ar Department of Hea	ant: If Ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	emetery, crem	atory or	emation 7/2		Sykesvill	
Balt permit. Departr	any inj		21. Signature of Funeral Service Licensee	- /			od Address of Facility FUNERAL HO ville, MD 21			
Exan	dical niner	Jer.	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	ons that caused the deat ause on each line. Due to (or as a consequence)	uence of):		tery dis		irrest,	Approximate Interval Between Onset and Death
s8760, ~	physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
Box 6	ed by the attending p deteched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic p Other (s	pregnancy pecify)		23d. Date of d Month	elivery Day Year
rds, P.	5.8	ρ	Part II. Other significant conditions contrib	outing to death but not res	ulting in the un	nderlying	cause given in Part I.	1	tobacco use contribute Yes 2 No 3 I	to the cause of death? Probably 4 Minknown
The la	ete has been si page 2 should I	Completed						24a. Wa: auto perf 1 Yes	opsy prior to death?	autopsy lindings available o completion of cause of es 2 \(\text{No} \)
of Vita	certificete ha	Be	25. Was case referred to medical examiner?	pital: 1 ☐ Inpatient 2 🗹	ER/Outpatien	t 3 🗆 D	Other	eath (Check only	one) idence 6 □Other (Sp	angifu)
Vision of Attending Physic death.	To the Funeral Director: After this of completely filled in by the funeral directors.	ation; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work? 1 Yes 2 No		how injury occurred	recity)
Divis	il Directo ad in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. <i>(Specil</i>	ome, farm, stre	eet, facto	ry, office		(Street and Number or lown, State)	Rural Route Number,
Hospital	Funera	edical (en: To the best of my kno : On the basis of examina and manner stated.						
To the within 24	To th comp	Me	29b. Signature and title of centrier	1 Office	32	25	DOD 7776		29d. Date signed (Mo	nth, Day, Year)
	10		30, Name and address of person who comp	· 11 Cyl	23a) Aype,	Pillio	hnston, M	Cord	RD Ra	halls town !
F	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 3 2	32. Registrat's Sign	ature	hor			1 - 7 1 000	21133

1 - For State Registrar

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Cecil Clark Cope

100	Examir		4a. Facility Name (/	f not institution, giv	e street and number)	1 Cont	h	4b. City, Town, o	or Location of Deat		4c. C	ounty of Dea			
		М								wson		В;	altim	016	
	Funeral Director		5. Social Security N 230-30-07 Usual Residence of	759 !	Sex 7. Age 7. A	e (In yrs. last b	Yrs.	Months Days	If Under 24 Hrs Hours Min.		2, 192	9. Bir	thplace (Sta ountry) VA	te or Foreign	
	yland low at		10a. State	10b. County		10c. City, Tox	wn or Loca	ation					10d. inside	e City Limits	
	a-f sh	ctor	MD	Baltime	ore	E	Balti	more					1 🗆 Y	∕es 2□No	
	or 28	Dire	10e. Street and Nu					10f. Zip Code			10g. Citize	en of What Co	ountry?		
	s 23a	ral		lynn Ave			1		21207		USA				
	fter de r item Ilner r	Funeral Director	11. Marital Status 1 □ Never Marr	ied 2□ Married	12. Was Decedent E Armed Forces?				Hispanic Origin? (S oan, Mexican, Puer	Specify Yes or Note 1 (1) The Rican, etc.)	0- 14	Black, White		19	
98	ours a	by	3X Widowed	4 ☐ Divorced	1 TYes 2 ☐ N If Yes, Give Year or Dates:]	Korea	11	□Yes 2DANo	Specify:		S	Specify: W	hite		
5	"natu	letec	(Spec	15. Decedent's Ed cify only highest gra	ducation ade completed)	16	a. Decede	ent's Usual Occup ind of work done	pation during most of wo	rking	16b. Kind	of Business	/Industry		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	+)	_	s Operat			Pag	kagin	Çr.		
	be filed Ital Hygi od other event, t	Be C	17. Father's Name)					me (First, Middle			5		
Maryland	should b ind Ments marked	To	Jesse						Della						
Mar	12 sho	l g		ame/Relationship (Type. Print) rsten (Daug	thtor)	b. Mailing	Address (Street	and Number or R	ural Route Numi	per, City or T	Town, State,	Zip Code)		
	1 and 2 Health tem 27 ather tra	- 8	20a. Method of Disp		Tatell (Dau)	20b. Place	of Disposi	ition (Name of	- 1	Date		Z11UZ ation - City or	Town State		
ē	Pages nent of int: if its iry or o		1 X Burial 2		Removal from State	cemet	ery, crema	atory or other pla aptist (/23/07		oon, M			
Baltimore,	permit. Page Department Important: If any Injury or once.			uneral Service Licer	nsee		-			ME & CH				95)	
	8 Q E # 9	2700	P Or			M00764			NERAL HO Le, MD 21			5-1400			
			shock, or hea	irt failure. List only	plications to t caused one cause on each lin	ie.					arrest,		Approxii Interval Onset a	mate Between nd Death	
1	Physician /Medical		disease or condition resulting in death)	in a	a. Due to (or as			THE TIME	FARCTIO	N			_		
	Examiner		Sequentially list co	nditions				IOMYOP	YHY						
	ed sit	iner	if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or as a		,	PT-L A 1011 NO 2014 NO							
₽.	execut and al-tran	Examiner	that initiated events resulting in death) I	3 ' '	c. Due to (or as a			RY DISE	-ASE						
68760,	icate be executed physician and s the burial-transit	calE			d										
89 ×	nat the death certificate be executed d by the attending physician and letached for use as the burial-transit	Physician/Medical	IF FEMALE:					-							
Вох	death certifica attending ph	ian/	23b. Was deceden in the past 12	months?	23c. If yes, outcome	2 Fetal deal		Ectopic pregnanc	ry		23	d. Date of de Month	livery Day	Year	
P.O.	the de	nysic	1 □ Yes 2 □ 9 □ Unknown	□No	4□Pregnant at 9□Unknown	time of death	51.1	Other (specify) _					,		
	₽ 0 0	by Pł			contributing to death bu	it not resulting	in the und	derlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to	the cause	of death?	
Vital Records,	The law requires ate has been sign bage 2 should be	ted t	AORTIC A	ANEURYSM						1 💢	Yes 2□	No 3∏P	robably 4	□Unknown	
<u>မ</u>	e 2 sh	Completed	RESPIRATO	ORY FAILU	RE					24a. Was	psy	24b. Were a	utopsy findin	gs available of cause of	
<u>=</u>				LAR ARRYT	HMIA					perf 1□ Yes	ormed? 2 X No	death?	2 X No		
	sicial certificacto) Be	25. Was case refer examiner? 1 ☐ Yes 2 🛣		Hospital:	nt 2 ☐ ER/O	tmatiant	all DOA Oth		ath (Check only					
ō	ding Phys h. After this funeral dir	n: To	27. Manner of Deat	h	28a. Date of Injur (Month, Day	y 28b.	. Time of	3 □ DOA □ UIII		Home 5 ☐ Res 28d. Describe			ecify)		
<u>S</u>	endin sath. or: Aff	atio	1 Natural 2 ☐ Accident	5 ☐ Pending investigation		real)	Injury		Yes 2 □ No						
Division or	or Att fter de Directe in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju building, etc	ry - At home, f :. (Specify)	farm, stree	et, factory, office		28f. Location City or To	(Street and wn, State)	Number or R	ural Route N	lumber,	
_	spital ours a neral E		29a. Certifier	Certifying Ph	ysician: To the best of	of my knowledg	ne death	occurred at the ti	ime date and plac	e and due to the	a coupe(s) a	nd mannar a	a atated		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director,	Medical	(Check only one)	2 Medical Exar	miner: On the basis of and manner sta	examination a	and/or inve	estigation, in my	opinion, death occ	urred at the time	, date and p	lace, and du	e to the caus	se(s)	
	To the To the Comp	Me	29b. Signature and	title of certifier	.11		M					signed (Moni		r)	
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	2		30. Name and addr		completed cause of de INTHICUM				מווזמת סב	TOUC	SCINI.	MAD	T AND	54504	
	Sta	te	31. Date filed (Mon	th, Day, Year)		r's Signature	760	ri Dore	R DRIVE	E TOWS	, VIU	инкү	LHND	21204	
	Registi		J	UL 2 3 20	107	W-	-	No.							
DHI	MH 17 Rev 1/2	001			Jan Ballot Van	J.J.	A STATE OF THE PARTY OF THE PAR								
							ORI	GINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death

3. Time of Death

JULY 19.2007 11:25F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:45 PM DAVIS 07 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mt. Holly Baltimone 1000 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 220.64.9571 1 □ M 2 ▼ Yrs 06 26 1947 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r 28a-f show notified at Baltmore 1 XYes 2 □ No MD Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or 2 must be n Pages 1 and 2 should be filed within 72 hours after death with 'nent of Health and Mental Hygiene. Woodyear USA Iral", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 **X**ONo If Yes, Give Year or Dates: 1XNever Married 2☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Back 3 ☐ Widowed 4 ☐ Divorced "natural" er than "nature , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hotel Industry HouseKeeper 10th grade 7 is marked other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Murrel Joseph ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Avenue Nicote F. Powell /Dauanter item 27 i other tra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 23/07 Windsor Mill, MD Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Vaugun C. Oreene Funeral Srucs 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4905 York Road Baltmore MO21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atheroscleratic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner incontrolled Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties of 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed non-compliance 24a. Was an autopsy performed? 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No Medica 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ŽX No 4 ☐ Nursing Home 5 ☐ Residence 6 ★Other (Specify) 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 5 ☐ Pending investigation Natural 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certified 1)6258

State

r Street

Baltimore MD 21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

He

Year) 1 2007

ara

31. Date filed (Month, Day,

			For State Registrar	• •		d / Depa		of H	ealth a		ental Hygi	iene	. 7	2315)
	Physicia /Medic		1. Decedent's Name (First, Middle, Last George A. Evans,								2. Date of Death Month		Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Keswick Home	street and num	ber)		4b. City, 1		Location o			4c. County of		
	Funeral Director		5. Social Security Number 6. Se 215-22-4614	x 7 2M 2□ F	. Age (In yrs. la B2	ast birthday). Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 06-27-1	Year) 9 2 5	9. Birthp Cour Mary	place (State or Foreign htry) Land
	Aaryland f ahow ed at	ō	Usual Residence of Decedent 10a. State 10b. County MD Baltimor	a		Town or Lo	cation						1	0d. Inside City Limits 1 ☐ Yes 2 ☑No
	with the ha or 28a-	Direct	10e. Street and Number 1528 Providence R				10f. Zip	Code 286			10	og. Citizen of W		ntry?
36	2 should be filed within 72 hours after death with the Maryland and Memlar Hygiene. Is marked other than "natural", or Itams 23a or 28a-f ahow eumatic event, the Madical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 XYes 2 If Yes, Give Year or Dat	es? ! 🗌 No		Vas Decede f Yes, spec		spanic Origin, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		, White,	
Maryland 21215-0036	within 72 hou ine. Ihen "neture ie Medical E	mpleted	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1		life. L	lent's Usua kind of won DO NOT us	k done d e retired)	urina most	t of worki	ng	16b. Kind of Bus		_{dustry}
and 2	il Hygi other	Be	17. Father's Name (First, Middle, Last)	2+		PI	SESTUE				(First, Middle, M	faiden Sumame		IIDOST CTO! I
Maryla	d 2 should h and Men 7 le marke treumatic	၉	George A. Evans 19a. Informant's Name/Relationship (7) Augusta Evans/Wif	ype, Print)					nd Numbe	r or Rura	. Quense Na Route Number. WSO⊓, MC	City or Town, S		Code)
ď	permit. Pages 1 and 2 should by Depermitment of Heatil and Menta Important: If Item 27 Is marked any Injury or other treumatic average.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation	Removal from S	20b. Pi	ace of Dispo emetery, cren 11awn [sition (Nam	e of her place	a)		ate 2	oc. Location - 0 المحتودة المحتودة المحتودة المحتودة المحتودة المتتوادة المتتوادة المتتوادة المتتوادة المتتواد		own, State
Baltii	permit. F Depertme Importer any Injur		21. Signature of Sin-Mi Second Licens	00	1	1	1050 Y	/ork	Rd	Tοω	son. MD	21 204	ıl Ho	ome, Inc.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failere. List only o Immediate Cause (Final disease or condition resulting in death)		r as a consequ		er the mode	of dying	, such as	cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	icate be executed physicien and s the burial-transit	lical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequ									
P.O. Box 68	attending for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal nt at time of de	death 3□	Ectopic pre Other (spe					23d. Date Mon		ery Day Year
ds, p	w requires thet the de been signed by the s should be detached	d by Pr	Part II. Other significant conditions co	- 1	th but not resu	-	nderlying ca	use give	n in Part I.					ne cause of death?
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of Vita	hysician: his certific il director,	To Be (1 L tes 2 Mo			ER/Outpatien		A Othe	IT: 4 □ NG		n (Check only one		r (Specif	y)
Division of Vital Records,	To the Hospital or Attanding Physician: The law within 24 burus after death, within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1	28e. Place o	Injury , Day Year) of Injury - At hog, etc. (Specify		М		at ? ′es 2 ☐ !	No	28d. Describe ho 28f. Location (Sti City or Town	reet and Numbe		al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai Ce	29a. Certifier Certifying Phy (Check only one)	rsician: To the biner: On the bas	is of examinat	wledge, death	occurred a	at the tim in my op	e, date an	d place, a	and due to the ca	iuse(s) and mar ate and place, a	ner as s	tated. o the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier	v W.O			-	License	number			9d. Date signed		* '
2	0 1/2		30. Name and address of person who co	ompleted cause		23a) (Type,					Baltir	NORES	nav	Yland
į	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 3	32. Re	gistrar's Signat									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7: 20A M WILLIAM JAMES EVANS 20 2007 July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Roland Park Place Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Wovember 9, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Yea Mary I and 214-27-5792 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director Baltimore Maryland None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 21211 USA 830 West 40th Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes XXNo Specify: White 2 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Law permit. Pages 1 and 2 should be filed or Department of Health and Mental Hygit Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Redding John Lewis Evans 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 211 Galyn Drive Brunswick Maryland 21758 Olivia M Evans 20a. Method of Disposition 1 ☐ Burial 2XXCremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 ☐Removal from State Green Mount Crematory 7/23/07 Baltimore, Maryland ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral vice Ligensee Lennis ZI 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 36 Hours 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) reumonia Physician /Medical Due to (or as a consequence of): Examiner clementia Years: rol-Stage Sequentially list conditions, if they, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 D. abeter mellitus 2 1 No 3 Probably 4 Unknown 1 Yes Completed perfections 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Seath (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 1 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Prineral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hosp within 24 hor To the Fune completely fi

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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and manner stated.

32. Registrar's Signature

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JUL 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MACGREGOR

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

013657

830 W. 40 th STREET, BALTIMORE,

29d. Date signed (Month, Day, Year)

20,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 19a, per FH, g869, 7/27/07 TI Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Ruth C. Foster 18, 2007 8:20P M July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9905 Lyons Mill Road Owings Mills Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 97 Director 009-09-0521 April 1,1910 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Ex miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9905 Lyons Mill Road 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warren Cartwright Mabel Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9905 Lyons Mill Road, Owings Mills, MD Wesley Foster Step Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pittsfield Cemetery 7/24/07 Pittsfield, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road deples Reisterstown, MD 21136 Eline Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -ongestive YEAU'S /Medical Due to (or as consequence of) Examiner pertension Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of page 2 s performed? Yes 2 No death? 1 ☐ Yes 2 □ No Division or Vital 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No ို 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation Injury n 24 hours after death. ne Funeral Director: Af oletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the comple 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig

Registrar

State

Alexander

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M0 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1-155ELL **Physician** ARBARA 8:15 AM JUL 2007 03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Future Care Old Court Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sept 18, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1111 K **Funeral** Year) 1924 Months Days Hours Min. 1 □ M 2 💢 F 216-22-0189 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at MD Baltimore 1 ☐ Yes 2√ No Randallstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5412 Old Court Road 21133 USA permit. Pages 1 and 2 should be filed within 72 hours after death: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23: any Injury or other traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation un : 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5412 Old Court Road Randallstown, MD Future Care Old Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 🖾 Other (Specify) in state Sunature of Funeral Service Licensee Ronald S State Anatomy Board 655 W. Baltimore Street 21201 2221 Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Corcinoma **Physician** plan resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pleadies ro intentional 4 Unknown 3 ☐ Probably 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient P 2 ER/Outpatient 3 DOA nours after death. neral Director: After this filled in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signatur and title of certifier

ERAHALLI

HARISH. 5310 32. Registrar's Signature *---**ORIGINAL**

person who completed cause of death (Item 23a) (Type, Print) 50 (1)

THYSICIAN

29c. License number 0 4 27 23

303.

OLD COURT

29d. Date signed (Month, Day, Year)

700G

Registrar

07-05494 Gary Gohean

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

iry Goriean		- For State Constant Contribution Certificate O		Reg. 1	No.	11 6040
Physician		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death Month Da	ay Year	3. Time of Death
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		Baltimore Washington Medical Center	Glen Burnie	. To Date of Birth (MM/DD/YYYY) 9. Bir	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours M	n	Forei	gn
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21215 21215 ould be file I Mental H marked ic event, I	<u>8</u>	Charles A. Gohean, JR.	ng Address (Street and Number of	Bean	City of Town State	to Zin Code)
D 21215-00; should be filed within and Mental Hygiene 7 is marked other that in the Med	٩		N. Keim St., Po			ic, zip code,
Z pd 2	ŀ		osition (Name of cometen)	Date 3	20c. Location - City of	or Town, State
Baltimore, permit. Pages 1 ar Department of He Important: If the injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or	other place)King of 07	7/19/2007	Bridgepor	t, PA
Pag ment tant:		4 Donation 5 Other Specify.	Crematury			
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100	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	D5D York Rd., To r the mode of dying, such as cardia	or respiratory arres	21.204 t, shock, or heart	Approximate Interval
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Division of Vital Records, ra or Attending Physician: The law requir rs after death. al Director: After this certificate has been shed in by the funeral director, page 2 should the control of the cont	٤.	1	of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
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DIVI Spital or tours afte neral Dir filled in	Certification:	Suicide Could not be determined (Specify)		or rown, se		
D Hospital 24 hours Funeral tely filled		29a, Certifier , Continue Physician: To the best of my knowledge death or	ccurred at the time, date and place,	and due to the cause	e(s) and manner as s	stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.		ed at the time, date a		
F 3 F 8	Me	29b. Signature and title of certifier	29c, License number		29d. Date signed (Month, Day, Year)
		Califold	O.C.M.E.		July 18, 2007	
17		30. Name and address of person who completed cause of death (Item 23a)	61 A B 10 A B 10	24204		
X			enn Street, Baltimore, MD	21201		
St Regist	ate	1111 / 4 / 1111 / ATEN A 2 to 1 / 20	Coords			

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ORIGINAL

OCME

			1 - For State Registrar	State of Maryla	ind / Depa		t of H	ealth a		lental Hyg	jiene eg. No.	07	23464
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MARY	HELWEI	CK					2. Date of Dea Month	th Day ZOZ	Year	3. Time of Death
¥ %	Examin	_	4a. Facility Name (If not institution, give st Lorien Columbia		ehab		Town, or 1umb	Location of	Death	ı		ty of Death ward	
	Funeral Director		5. Social Security Number 6. Sex 1 \square		s. last birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Feb. 17,	1919	9. Birth Cou Mary	place (State or Foreign Intry) Land
	aryland show	70	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the Mi or 28a-f	Director	Maryland Baltimo	ore	Catonsv	10f. Zip					10g. Citizen of USA	What Cou	
	r death w	Funeral	3 Ginford Place	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	212 lent of Hi		jin? (Spe	ecify Yes or No- Rican, etc.)		ace - Amer	ican Indian,
0036	ural', or it	d by Fu	1 ☐ Never Married 2 ☐ Married 3 【 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1□ Yes 2	2 X No	Specity:			Spec	iny:	hite
1215-	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or itema 23a or 28a-f show do other than "natural", or itema 23a or 28a-f show event, I've Medical Examinar must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usua kind of wor DO NOT us memak	rk done d se retired	ation during most)	of work	ng	Own H		ndustry
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In proportent: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic event, the Madical Examinar must be notified at once.	Be	11 17. Father's Name (First, Middle, Last) Henry C. Thompson		, inc	meman				iller	Maiden Suma	ıme)	
Maryl	d 2 should th and Me t7 is mark traumati	2	19a. Informant's Name/Relationship (Typ Henry L. Helweick	e, Print)						al Route Numbe	-		ip Code) MD 21042
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Baltimore,	permit. P. Departme Important any injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Experiment Service Licenses	7 2	loodlawn	i Ceme 2. Name an ineral	d Addres	ss of Facility	Ste	rling Asonsville	shton S	Schwal	b Witzke D 21228
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P.O. Box 68	ath certifica ittending pl or use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ic. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3[⊒Ectopic pr ⊒ Other (sp						ate of deli	very Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cont	ributing to death but not r	resulting in the u	anderlying c	ause givi	en in Part I.			bacco usa co es 2 □ No		the cause of death?
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ion of	Afte	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o		8c. Injun Worl	/ at		28d. Describe h			ayy
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amend items 23a b pt 11 per doc 869 7-23-07 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Menth 150 am 2001 MARY HORTON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Under 1 Year | If Under 24 Hrs. 7. Age (In frs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗶 F Hours **Director** 212-30-9274 -4 - 1936NC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 Yes 2 □ No MD Directo BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1650 N. MONROE STREET 21217 USA Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò, 1 ☐ Yes 2 🔀 No þ Specify. 3 Widowed 4 □ Divorced "natural" BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: if item 27 is marked other this any injury or other traumatic event, the once. 12 **SEAMSTRESS** HOTEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 DANIEL LOFTON HENRIETTA HARRISON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LENORA SUMMERVILLE/DAUGHTER 1650 N. MONROE ST. BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 7-21-2007 BALTIMORE, MARYLAND 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee porton 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Urinary Tract Infection **Physician** Unu /Medical Due to (or as a consequence of) Sepsis Examiner Hilliorga if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last quentially list conditions Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypotension, Acute Renal Failure 1 Yes 2 No 3 Probably 4 1 Vnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical examiner?

1 res 2 No Be 26. Place of Death (Check only one) 1. Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aft

To the Funeral DI

completely filled in 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of poson who completed cause of death (Item 23a) (Type, Print) and Greneral X 31. Date filed (Month, Day, 32. Registrar's Signature Yegr) 2 State

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MARIE ANTOINETTE HYSON JULY 2007 20. 1:00 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE GILCHRIST CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F Yrs. 214-26-2910 Director 9/29/1929 MARYLAND Usual Residence of Decedent 10a. State r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD BALTIMORE PERRY HALL 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 1 pe o ns 23a o must b 9602 AMBERLEIGH COURT APT. 21128 by Funeral USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? items 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) MARYLAND SCHOOL FOR Elementary/Secondary (0-12) College (1-4or 5+) THE BLIND 12TH GRADE ADMINISTRATIVE_ASSISTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental 27 Is marked of traumatic even PAUL PARRINELLO JOSEPHINE CULOTTA ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 CHARLES F. HYSON, III/SON 2212 LYNS COURT item 27 other t BEL AIR, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If its any Injury or o once. 1 ☐ Burial 2 ☐ €remation 3 ☐ Removal from State METRO CREMATORY, INC. 4 □ Donation 5 □ Other (Specify) 7/23/2007 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year ned by the a 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed to be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has be irector, page 2 s autopsy perform 1∐ Yes 2 🛂 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sther (Specify) WOSP (1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 2007 8303 0 30. Name and address(of person who completed cause of death (Item 23a) (Type, Print) N. Charles St J. CHARUES 0701 NV 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 2007 **Physician** 1035 AM Mary Margaret Hyson */Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center | Months | Days | Hours | Min. | Dec. | Month, Day, Year | 1931 Westminster 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mary land 1 ☐ M 2 💢 F 75 Yrs 218-26-5885 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. In the Mental Hyglene and It Item 27 is marked other than "natural", or Items 23a or 28a-f show ant; If Item 27 is marked other than "natural", or Items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Union Bridge Carroll Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21791 2 Phillips Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Baltimore. Maryland 17. Father's Name (First, Middle, Last) Be Margaret Schmidt Chesley Hall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Phillips Lane Union Bridge, MD 21791 Edward Hyson/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 7/21/2007 Sykesville 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Furieral Service Licens 6 E Broadway Union Bridge, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lutracranial **Physician** disease or condition resulting in death) /Medical Examiner Head Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Myziodysplasia Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2□ No 2 No 1 ☐ Yes Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1 Natural Fell getting out of N4: ON AM 1 Yes 2 No 7/20/07 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 P4: II ps Lane Union Bridge Ind. 21791 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar 29b. Signature, and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

M.P.

32 Registrar's Signature

5555

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D

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29c. License number

D15552

29d. Date signed (Month, Day, Year)

7/20/07

Westminster, and 21157

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	Physici /Medic		Decedent's Name (First, Middle, La. JOSEPH LUK	,	ITH				2. Date of Month	1	Day L6 2	Year 007	3. Time of Death 9:00 P ^M
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ŭ.	Funeral Director		5. Social Security Number 6. S 218-76-9396 Usual Residence of Decedent	ex 7. Age	e (In yrs. lasi 44	Yrs.	if Under 1 Year Months Days	If Under 24 Hours	Ain. (Monti	n, Day, Ye	1962		lace (State or Foreign try) yland
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5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N if Yes, Give Year or Dates:			Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2【XNo	spanic Origin' n, Mexican, P Specify:	? (Specify Yes o uerto Rican, etc	or No-		e - America k, White, e : Wh	
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baltimore,	permit. Departi Importi any Inj		21. Signature of Funeral Service Licer	$\langle O \cap O \rangle \langle O \rangle$	M01103		Name and Addres 3 Talbot					Home 0707	P.A.
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DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home :. (Specify)	, farm, stre		2 2 110	28f. Locati City o	on (Stree r Town, S	t and Number tate)	er or Rurai	l Route Number,
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1	5 1		30. Name and address of person who	completed cause of de	eath (Item 23	Ba) (Type, F							
d			Thomas A. Bensing				y Center	Drive	Greenk	elt,	MD 2	20770	
	Sta Registr	-	31. Date filed (Month, Day, Year) JUL 2 3 2007	32. Registra		Spend							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 State of Maryland / Department of Health and Mental Hygiene Per SA, 8872, 10/15/0/db Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 6, 2007 4c. County of Death 1600 Eunice E. Haywood /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salis Gur If Under 1 Year If Under 24 Hrs. 8 Dicomico isbury Rehab+Nursing Ctr. 8. Date of Birth (Month, Day, Year) Feb 27, 195 Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 😾 F Yrs. 57 1950 Maryland Director 213-65- Usual Residence of Decedent реттіt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County · 28a-f show notified at 1 ☐ Yes 2√☐ No **Funeral Director** MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number a or 21801 ms 23a must b USA 525 Algana Avenue #30 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner man 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married black. 1 ☐ Yes 2 X No Specify: Specify: þ Baltimore, Maryland 21215-603 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Thomas Elzey Martie Church ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Suni Algana Avenue #30 Salisbury, MD Donald Haywood/spouse Important; If Item 27 any injury or other tr once. 525 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S., Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) **Physician** lan core /Medical Due to (or as a consequence of) Examiner 100 ne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown as been signed by the 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? 1 ☐ Yes 2 No certificate 2 1 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ivic Ave Sa Robins H. ns, M.D. William

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) JUL 2 3

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month acris 9:55 AM lamus 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2 □ F 82 240-32-5161 14, 1924 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10b. County Baltimore 1

Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 535 Laurens Street 21217 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: black 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk <u>laborer</u> shoe company 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Theresa West/granddaughter 2107 Park Avenue #2 Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Signature of Ronal S. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Wade, Direct Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prostate and Bladde Metastatic Due to (or as a consequence of) equantiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

physician

attending p

signed by the a

has

certificate

this After thi funeral of

within 24 hours at er death To the Funeral Director completely filled in by the

The law requires that the death certificate be executed

Box 68760,

P.O.

Division or Vital Records,

or Attending Physician:

To the Hospitai

death.

Physician

/Medical

Examiner

10a. State

MD

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Director

Funeral

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Completed

Be

Funeral

Director

28a-f show notified at

"natural", or items 23a or

the Medical

Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the

e filed within 72 hours after dal Hygiene.

pe

Pages 1 and 2 should

Maryland 21215-0036

Baltimore,

death with the Maryland

disease or condition resulting in death) Examine sician and burial-tran

Physician/Medical

Completed

Be

၉

Certification:

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? ☐ Yes 2☐ No 9 Unknown

25. Was case referred to medical examiner?

1 ☐ Yes 2 X No

27. Manner of Death

1 🔀 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

24a. Was an autopsy performed? 1□ Yes 2⊠No

_ ,	prior to co	impletion of cause o
	1 ☐ Yes	2□ No

	26. Place of De	eath (C.	neck only one)	
OOA	Other: 4 Nursing	Home	5 Residence	6 □Other (Specia
	Injury at Work?		Describe how inj	

Injury at Work?	•	28d. Describe how injury occurred
1 Yes	2 🗌 No	

- 1				

	281. Location (Street and Number or Rural Route N City or Town, State)	umber
--	---	-------

29a. Certifier (Check only one)	2 Medical Examiner: On	To the best of my knowledge, death occu the basis of examination and/or investig d manner stated.	urred at the time, date and place, and due to the ation, in my opinion, death occurred at the tim	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
29b. Sigr[ature a	nd title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

1 Minpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29d. Date signed (Month, Day, Year)

of death Item 23a) (Type, Print)

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

Bon Secours Hospital 12000 West Baltomore Street Somo

3□ D0A

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

07-05517 Anthony D Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate o	f Death	Re	g. No.	51 100 41
Physici		Decedent's Name (First, Middle,Last)			2. Date of Death Month		3. Time of Death
edical Exam	iner	ANTHONY D. JONES			July 18, 20	007	1410 hrs
		4a. Facility Name (if not institution, give street and numbe Bon Secours Hospital	r)	4b. City, Town, or Location of I Baltimore	Death	4c. County of Dea	th
Funeral			ge (In yrs. last birthday)	If Under 1 Year If Under 2	Aldre P Date of Bird	h(MM/DD/YYYY) 9. B	orthologo (State or
Director	9	JWN	16	Months Days Hours	Min	Fore	ign
		1 X M 2 F	46 Yr	S.	10/03/	1960	Country) MD
any	•	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loca	tion			10d. Inside City Limits
* .	_	100					1 X Yes 2 No
Aaryland 28a-f show 1.at once.	cto	10e. Street and Number	BALT	TMORE 10f. Zip Code	10	g. Citizen of What Co	untry?
he Ma or 2	Director	10/0 3/00/3777 (777777777				180.	,
with t		1940 MOSHER STREET 11 Marital Status 12. Was Deceder		21217 as Decedent of Hispanic Origin	? (Specify Yes or No-	14. Race - Ame	erican Indian, Black,
death with the Maryland or items 23a or 28a-f sho	Funeral	11 Marital Status 1 Never Married 2 Married Armed Forces 1 Yes	s? If '	Yes, specify Cuban, Mexican, P	uerto Rican, etc.)	White, etc.	
	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 No specify:		Specify: B	LACK
15-0036 filed within 72 hours after I Hygiene. ed other than "natural", t. the Medical Examiner.		15. Decedent's Education (Specify only highest grade co	ompleted) 16a. Decede	nt's Usual Occupation (Give kin nost of working life, DO NOT us	d of work done	16b. Kind of Business	/Industry
136 hin 72 l e. than "1	Completed	Elementary/Secondary (0-12) College (1-4 o	(5+)		e reared)		•
5-0036 led within 72 ttygiene. other than the Medical	mo	17. Father's Name (First, Middle, Last)	1460	er Worked	(5)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C				Name (First, Middle, M		
2121: uld be fil Mental I marked c event,	.0	WILLIAM JONES 19a. Informant's Name/Relationship (Type, Print)	19b, Mailir	ng Address (Street and Number	IE MAE HAR er or Rural Route Num		te. Zip Code)
MD d 2 shoutth and n 27 is unmatic		WILLIAM JONES/FATHER			BALTIMORE,		
		20a. Method of Disposition		sition (Name of cemetery,	Date	20c. Location - City of	or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iter		1 XBurial 2 Cremation 3 Removal from S			7-23-2007	DAI TIMOD	DE MID
Baltimo permit. Page Department o Important: injury or oth	1	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	M1. Z1UN	CEMETERY Name and Address of Facility	JAMES A. M	BALTIMOR ORTON & SO	NS F.H., INC.
ii ii g g	K 7	James 9. morte		1701-31 LAUREN			
Physician		23a (Fart I. Enter the disease, or complications that cause failure. List only one cause on each line.	d the death. Do not enter	the mode of dying, such as card	tiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
'Medical .aminer	8 9	Immediate Cause (Final disease a. Narcotic	(heroin) intoxi	cation			Death
		or condition resulting in death) Due to (or as a con	sequence of):				
	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a con	sequence of):			_	
,	i.	(Disease or injury that initiated					
lisit ed A	Examiner	events resulting in death) Last Due to (or as a con	sequence of):				
executed in and il - transi	cal	X UNPENDED AMENDED					
760, ficate be ex g physician the burial	/Medical	#23a.27.28	Ba-f_perMF_0869 ome of pregnancy	, 7/25/07 TT		22d Date of delive	
	J/N	23b. Was decedent pregnant in the past 12 months?		etal death 3 Ectopic p	regnancy	23d. Date of delive Month	Day Year
30x 68 death certif te attending I for use as	sicia	1 Ves 3 No 0 Unknown 4 Pregnant a	at time of death	ther (Specify)			
Box he death of the atten hed for us	Physician	9 Olikilowii					
, P.O. Box 68' ires that the death certification is generated by the attending be detached for use as	by	Part II. Other significant conditions contributing to dea	ith but not resulting in the	underlying cause given in Part		bacco use contribute t	o the cause of death? obably 4 Unknown
ords, I w requires s been sig					24a. Was a		autopsy findings available
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should be	Completed				autops perfor	sy prior to	completion of cause of
Rec The I	Son				1 Yes 2		
ital Re- Iclan: The s certificate rector, page	Be	25. Was case referred to medical examiner?		26.Place of Death (Cl	neck only one)		
F Vi	၉	1 ✓ Yes 2 No	ient 2 🗸 ER/Outpatien			Residence 6 Oth	er;
= . `≥	on:	1 Natural E (Month, Day	Year)	Injury 28c. Injury at Work?	. .	ow injury occurred	
ivision or Atteneather death Director:	cati	2 Accident Investigation //1//200		eet, factory, office building, etc.	- Cuit	treat and Niverbarra	Date Name of the Control
Division spital or Attendir cours after death.	Certification:	Suicide & X Could not be determined (Specific)		et, factory, office building, etc.	or Town, St		Rural Route Number, City
IT S S IT		29a. Certifier	nk	urred at the time, date and sleep	unk	2/c) and manner as -1:	atod
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of ex	amination and/or investiga				
To To COTT	Mec	29b. Signature and title of certifier	l	29c. License number		29d. Date signed (M	onth, Day, Year)
A.		MAINTAIN IN		O.C.M.E.		July 19, 2007	
OKALLA		30. Name and address of person who completed cause of	death (Item 23a)				
100		Susan Hogan MD. Assistant Medical E	,	nn Street, Baltimore, MD	21201		
S	tate	31. Date filed (Month, Pay, Sear 2007 32 Registr	ar's Signature				
		001 2 0 2007	ATT ATT	ATTENTION OF THE PARTY OF THE P			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	olalo ol marjia.	Cei	rtificate of L	Death	Reg	J. No.	
E _{ph}	Physicia /Medic	40	1 Decedent's Name (First Middle I	ERVIN K	REIT	ZER		2. Date of Death Month	Day Year 18 2007	3. Time of Death
	Examin		4a. Facility Name (If not institution, go University of Mary	ive street and number)	enter.		More		4c. County of Death	h
	Funeral Director		5. Social Security Number 6. 219-14-7975	Sex 1 7. Age (In yrs. 84		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 18	9. Birtl Co. 3,1922 Ma	nplace (State or Foreign untry) aryland
	e Maryland 3a-f show tified at	Ctor	Usual Residence of Decedent 10a. State 10b. County aryland Carro		ity, Town or Lo	ter				10d. Inside City Limits 1 Yes 2 □ No
	th with th 23a or 28 ust be no	al Dire	aryland Carro 10e.Street and Number 3016 Wertz Av	re		10f. Zip Code 21102			g. Citizen of What Co	
036	d within 72 hours after death with the Maryland jlene. I han "natural", or items 23a or 28a-f show trhan "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married XXMarried 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1∑Yes 2□No If Yes, Give 3 -194 Yearlor Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes	ispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
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2121	e filed within al Hygiene. other than ' vent, the Me		11		Mail	Carrie	r 18. Mother's Name		J.S. Post	t Office
Maryland	d d o	To Be	17. Father's Name (First, Middle, La Ervin L.	•				A. Wi		
ary	2 should be and Menta is marked aumatic ev		19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street	and Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)
	s 1 and 2 f Health item 27 i		Vera Kreitzer			Wertz A			anchester	r, Md.21102
altimore,	0 0		20a. Method of Disposition 1 ↑ Burial 2 □Cremation 3 4 □Donation 5 □Other (Spe	□Removal from State Bix	cemetery, cre Klers	matory or other plac Church	ce) Cem. Jul	y 23,2	007 Westi	minster, Md
Bail	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Lic	Ra _	32	96 Char	mil Dr.	Manche:	ster, Md	
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the deally one cause on each line. a. Due to (or as a conse	ted					Approximate Interval Between Onset and Death
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	xecuted and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. tumor l	45/5	Syndra	me			
68760,	rtificate be executed ng physician and as the burial-transit	Medical E		c. tumor l Due to (or as a conse	myelo	ogenous	leuke	mia		
P.O. Box (ath ce ittendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregi 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date of de Month	livery Day Year
	quires that the de n signed by the a	by	Part li. Other significant condition	s contributing to death but not re	esulting in the u	inderlying cause giv	ven in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to	o the cause of death?
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Vital	ician: sertific ector,	Be (25. Was case referred to medical examiner?	Hospital:		at 2000 Oth	26. Place of Death			
ō	Phys	To	1 ☐ Yes 2 ♣No 27. Manner of Death	28a. Date of Injury	ER/Outpatie	III 3 DOX	4 LI Nursing Hor		nce 6 ☐Other (Spe w injury occurred	ecify)
on	Attending r death. ector: After by the fune	ation	1 Naturai 5 ☐ Pending 2 ☐ Accident investigat		Injury	l l	rk? Yes 2 □No			
Division or	al or Atte s after dea il Directo	Certification:	3 Suicide 6 Could no 4 Homicide determin			reet, factory, office	2	28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C		Physician: To the best of my kr xaminer: On the basis of examin and manner stated.						
	To the To the Comp	M	29b. Signature and title of certifier	no ho	nD	29c. Licens	se number		d. Date signed (Mon	
			· But w	7 7 7 1	OC-1 /T				July, 18,	
_	10		30. Name and address of person w Sava Hand	ho completed cause of death (Ite	rsity	of Maryla	and Med C	tr, 22	S. Greene	St, Baltimore Maryland, 21201
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	N. D.			ſ	varyland, 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Man		artment of H rtificate of L			ene	231173
901	Physici /Medio		Decedent's Name (First, Middle, Last	vn.	Kea	ronely.		2. Date of Death Menth July	Day A Year	3. Time of Death 2:42AM
	Examir		4a. Facility Name (If not institution, give GOOD SAMARITAN	HOSPITAL			Location of Death ORE CITY If Under 24 Hrs.	V	4c. County of Death	
li fine	Funeral Director		5. Social Security Number 6. Se 212-14-0073 Usual Residence of Decedent	X	n yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 4/3/192	Year) 9. Birth Co. O MAR	place (State or Foreign intry) YLAND
	death with the Maryland me 23a or 28a-f whow Linual te notified at	ctor	10a. State 10b. County MD BALTIM		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 XNo
	with the a or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
36		by Funerai	1613 YAKONA ROAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 M Yes 2 No If Yes, Give Year or Dates: 1,7		Was Decedent of Hi If Yes, specify Cuba	286 spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - Amer Black, White Specify: WH	
1215-0036	within 72 hours after ene. than "natural", or its re Modical Exemina	Completed t	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work	ang	6b. Kind of Business/li	ndustry
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<u>ya</u>	should be nd Menta marked umatic ev	5	MORRIS F. KEARNE		10h Maife	- Address (Casas		INE E. PO		i- Ordel
	Pages 1 and 2 sinent of Health and the firm 27 ler int: If item 27 ler int or other traur		BERYL KEARNEY/WITE 20a. Method of Disposition Burial 2 Cremation 3 F	Removal from State	7977 20b. Place of Dispo	BOLDREW_	AVENUE	TOWSON, I	City or Town, State, Zi ID 21204 Oc. Location - City or T	own, State
Baltimore,	permit. P. Departme Importent any injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		22		s of Facility TH	E JOHNSON	BALTIMORE, N FUNERAL P SON, MD 2	
8760,	Physician /Medical Examiner and the prujate and the prijate an	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the shock of heart failure. List only of the shock of the	ne cause on each line. a. Buddle Due to (or as a c	onsequence of): alony onsequence of)	neur Just loper	g, such as cardiac nomá bee ffi	or respiratory arres	1	Approximate Interval Between Onset and Death
O. Box 6	death certific e attending p id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of a 1 Live birth 2	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
rds, P.	es tha	by	Part II. Other significant conditions co	ntributing to death but n	not resulting in the u	nderlying cause give	en in Part I.		acco use contribute lo	v./
Vital Hecords,	The law ate has b page 2 sl	Completed						200	ed? prior to condeath?	opsy findings available ompletion of cause of
	Physicial this certi al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien	nt 3□ DOA Othe	Ar-	h <i>Check</i> only one ome 5 ☐ Resider	nce 6 ☐Other (Spec	ify)
Division of	ling I	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Work	rat (? Yes 2 □ No	28d. Describe hov	v injury occurred	
Ë D	e Hospital or Attenc 24 hours after death e Funarel Director: etely filled in by the i		4 Homicide determined	28e. Place of Injury building, etc. (Specify)			City or Town,		
	o the Hospital or within 24 hours afte o the Funarel Dir ompletely filled in	edical	29a. Certifier Check only one) Certifying Phy 2 Medical Exami	rsician: To the best of n iner: On the basis of ex and manner stated	amination and/or in	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
-1	within 2 To the complet	W	29b. Signature and title of certifier	Tupo	maen	29c. License	30661	29	d. Date signed (Month Tury 24 FLA - 2	2007.
M			30 Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type,	Print)	zalten	mole.	FCd - 2	1239
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 3	32. Registrar's	Signature	halls				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 July 17, **Physician** 1:41 AM CHARLES LOUIS KENNEDY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 Reldas Court, Apt C Baltimore County Cockeysville 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Macyland 8. Date of Birth (Month, Day, Year) Nov 27, 1934 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 72 Yrs 218-32-3552 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show Examiner must be notified 1 Yes 2 No Directo Baltimore County Maryland Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Reldas Court, Apt C 21030 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 52-60 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Balto. County School Elementary/Secondary (0-12) 12 College (1-4or 5+) Groundsman System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin James Kennedy Mary Elizabeth Steinhagen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ann M. Kennedy (Wife) 5 Reldas Court, Apt C., Cockeysville, MD 21030 20a. Method of Disposition *☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jessop Meth. Ch. Cen. 7/20/2007 | Cockeysville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign de peral Service Nicenyee MCCHECC-WIEDETELD FUNERAL HOME, INC. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NON SMOULEU LUNG CANCER **Physician** METASTATIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy detached for u in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No death? 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

ECIC Ga...,
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Ecic Carr, MD, 12221 Tullamore Road, Timonium, Maryland 21093

32. Registrar's Signature

29c. License number

053095

29d. Date signed (Month, Day, Year)

07-05530 Darlene Anne Lee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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niene /	Allie Le	1-	For State Crivial yield Certificate of Death	Reg.	No.	
	hysicia	n/	1. Decedent's Name (First, Middle,Last) DARLENE ANNE LEE	2. Date of Death Month D July 19, 200)ay Year	3. Time of Death 0627 hrs
edical	Examir		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De		4c. County of De	ath
			8444 Foundry Street Savage	,	Howard	
F	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9.1 For	eian
Di	irector		213-74-8482 1_M 2XX 65 Yrs. World's bays 1663	July 11	, 1942	Country) Maryland
	ř		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
_	10w any		Maryland Howard Savage			1 XXYes 2 No
in land	28a-f show	O 1_	10e. Street and Number 10f. Zip Code	10g	. Citizen of What C	ountry?
A S	ut the Maryland 23a or 28a-f sho notified at once.		8444 Foundry Street 20763	_ =	U.S.A.	
#	ms 23.	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - An White, etc	nerican Indian, Black,
thoops	or ite	Funeral	1 Yes 2 XX No		Specify:	White
4	ural",	<u>\$</u>	or Dates: 15. Recorded Education (Specific only highest grade completed) 16a Decedent's Usual Occupation (Give king	d of work done	16b. Kind of Busine	
2	/2 hou	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	e retired)		
036	ed within / Iygiene. other than	du	Grade 6 House Cleaning	Name (First, Middle, Ma	Cleaning	(ARC)
215-0036	Hygi Hygi d oth		17. Patiers Name (First, Wilders, Edity)	otte Bell	alderi odinianic)	
212	Menta Marke marke	ш,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number		er, City or Town, S	tate, Zip Code)
, MD 21215-0036	ages I and 2 should be tried within 72 nt of Health and Mental Hygiene. t: If item 27 is marked other than 'other traumatic event, the <u>Medical</u>		Ralph Gilbert Lee / father 8444 Foundry Street		Maryland	20763
e .	I and Healt Fitem er trau		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	y or Town, State
ō E	Pages nent of ant: I)	Savage Cemetery	7/23/2007		Maryland
Baltimore,	permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med injury or other traumatic event, the Med		21. Signature of Dinaral Service Licensee 22. Name and Address of Facility Donaldson Funera M00770 313 Talbott Aver	al Home, P	.A.	
	ysician		23a. Part Enter the rule, se, or complications that caused the death. Do not enter the mode of dying, such as card	nue Laure diac or respiratory arre	I, Maryla st, shock, or heart	Approximate Interval Between Onset and
/8	Madical		failure. List only on cause on each line.			Death
≟X	aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
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.60,	ate be shysici ne buri		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	
687	certific nding p	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic p 4 Pregnant at time of death 5 Other (Specify)	pregnancy	Month	Day Year
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ord	aw req nas bee 2 shou	plet			med? dea	
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<u>ta</u>	ician: The s certificate rector, page	Be	examiner? Hospital: 4 Instrinct 3 ED/Outsetient 3 DOA Other		Residence 6	Other: Scene
)c	ding Physi After this funeral dir	-	1 Yes 2 No 28a Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe I	now injury occurred	
ē	ath. or: Af the fun	tion	1 ✓ Natural 5 Pending 2 Accident Investigation (Month, Day,Year) 1 Yes 2 N			
Division of Vital Records,	or Attend after death Director:	≔	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	. 28f, Location (S or Town, S		or Rural Route Number, City
Ö	spital nours a neral	Cert	4 Homicide determined (Specify) 29a. Certifier Continuo Physician: To the best of my knowledge, death occurred at the time, date and place	on and due to the caus	ea(s) and manner as	stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred as the death o	urred at the time, date	and place, and due	to the cause(s)
	To To Com	Med	and manfer stated. 29a, Signature and title of certifier 29c, License number		29d. Date signed	(Month, Day, Year)
	/		O.C.M.E.		July 19, 200	7
1	Y		30. Name and address of person who completed cause of death (Item 23a)	ID 21201		
Q			Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	21201 טוי		
		State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

07-05389
Andrew Lemischka

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e Legible.			100				~ 7	
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		1- For State Registrar		Ce	rtificate of	Death		R	eg. No.	
Physici		1. Decedent's Name (First, Midd	le,Last)					2. Date of Dea	ith	3. Time of Death
Medical Exami	ner	ANDREW	LEMISC	HKA, M	I.D.			July 14, 2	Day Year 007	1444 hrs
		4a. Facility Name (if not institution				b. City, Town, or L	ocation of	Death	4c. County of	Death
		Carroll Hospital Cente	er			Westminster			Carroll	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year				Birthplace (State or
Director	-	203-26-0241	1 XM 2 F	9	37 Yrs.	Months Days	Hours	Min.	7,1919	Foreign Country)UKRAINE
		Usual Residence of Decedent			, ,			1001.	7,1010	OKKATNE
any.		10a. State 10b. County		10c. City	, Town or Locati	on				10d. Inside City Limits
≥ 10	L	MD	N/A		BALTI	MODE				1 XYes 2 No
rylar la-f s	Director	10e. Street and Number	,		D.11011	10f. Zip Code			l0g. Citizen of Wha	t Country?
e Ma or 28	ire	2608 E. BALTIMORE STREET 21224 U.S.A								
ith th		2008 E. B.		STREE edent Ever in U		212		-0 (Cif-V)	U.S	. A . American Indian, Black,
tems	Funeral	lumi lumi	arried Armed F	orces?				n? (Specify Yes or No Puerto Rican, etc.)	White,	
or dea	ᆵ		1 Yes	2X No		v	:5		0	LILL TO TO
nine safe	ρ	3 XWidowed 4 Div	or Dates:			Yes 2X No		and afternational	Specify: 16b. Kind of Busi	WHITE
hours af	Completed	Elementary/Secondary (0-12)						se retired)	. Kind of Busi	ness/industry
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215-0036 be filed within 7 rad Hygiene. ked other than ent, the Medica			,	7.		Γ'				
212 212 ould be Menta marke c even) Be	MATVIJ 19a. Informant's Name/Relations	LEMISCHK	A	10h Mailing	Address (State)		ANNA per or Rural Route Nu	N/A	Chata Ti- Cada)
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f short traumatic event, the Medical Examiner must be notified at once	T _o	IHOR LEMI		ONI	1.0				-	
- p + e z		20a. Method of Disposition	SCHKA/ S			UEENSTC		ACE, PRI		NJ 08540 City or Town, State
nore, ages I a nt of He nt: If ite		1 XBurial 2 Cremation	n 3 Removal fr	om State	crematory or oth	er place)				
E E o : - 1		4 Donation 5 Other S		ST	. MICH	AEL'S U	KRAI	NIAN 7/2	0/07 BA	LTIMORE, MD
Baltimo permit. Pag Department Important: injury or of		21. Signature of Funeral Service	Licensee		22.N	ame and Address	of Facility	R INC. F	TIMEDAT.	HOME
T. B. G. B. CO) B	- de	2 Star		119	01 EAST	ERN	AVENUE, B	ALTIMOR	E,MD 21231
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the death	. Do not enter th	e mode of dying,	such as car	rdiac or respiratory an	rest, shock, or hear	t Approximate Interval Between Onset and
/Medical	8 14	Immediate Cause (Final disease	A 411-	rotic Cardio	vascular Dise	ease				Death
Examiner		or condition resulting in death)		consequence of	of):			V 10 10 10 10 10 10 10 10 10 10 10 10 10		
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8760, iffcate be	Jed	IF FEMALE:	23c If yes	outcome of preg	nancy				23d. Date of d	eliven
	اڃَ	23b. Was decedent pregnant in the past 12 months?				al death 3	Ectopic	pregnancy	Month	Day Year
Box 68 e death certiful the attending ed for use a	i Si		4 Pregr	ant at time of de	ooth	er (Specify)				
e dea	Physicial	1 Yes 2 No 9 Un	known g Unkno	own						
Division of Vital Records, P.O. Box 68' for the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant condi	ions contributing to	death but not r	resulting in the u	nderlying cause gi	ven in Parl			ute to the cause of death?
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is cer	Be	examiner?	Hamital: -	nnatient 2 🗸	ER/Outpatient		Othor:	Nursing Home 5	Residence 6	Other:
Phy eral d	P	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time of Ir	· · · ·	y at Work?		how injury occurred	
n of Iding Pl h. : After e funera	<u> </u>	1 Natural 5 Pen	(Month	, Day,Year)		· · I ·	es 2			-
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Division of oppositation of thous after death, neural Director: After the filled in by the funeral	Certification:	dete	d not be (Specify)	e or injury - Acti	ione, iain, si ee	t, factory, office bu	inding, etc.	or Town,		or Rural Route Number, City
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To the Hos within 24 h To the Fun completely	g	(Check only Certifying P						e, and due to the cau urred at the time, date		
To the within 2 To the complet	Medical		and manner s	tated.						
	2	29b. Signature and title of certific	L	20		29c. License				(Month, Day, Year)
V		dont	4977	V		O.C.N	/1. ⊏.		July 15, 200	1
7 1	Ī	30. Name and address of person								
2"		Tasha Greenberg MD	. Assistant M	edical Exam	niner 1111	Penn Street, E	Baltimor	e, MD 21201		
	tate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signat	ure					
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 19Day 2007 8:30 рм Darlene L. Loughrey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Hours Min. 1 □ M 2 🔀 F 78 133-20-3332 Director New York 10, 1928 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at other. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 → No Baltimore Directo Timonium Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2300 Dulaney Valley Rd. 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2X ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Beckstead Lester Newton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1910 Upper Forde Lane Hampstead, Md. 21074 Mrs. Linda Yost/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 7-23-07 Towson, Md. 21. Signature of Fungal Sprvice 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Ent. r the disease or competitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🙀 No
9 ☐ Unknown Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE P 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Vear Month \mathbf{a}^{M} Nelson Edward Lukemire, Jr. July 20, 2007 7:32 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Greater Baltimore Medical Center If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☑ M 2 ☐ F Days 089-30-9714 69 1937 Oct. 1, <u>Tennessee</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Harford Darlington 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21034 3510 Dublin Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financial Advisor Finance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelson Edward Lukemire, Sr. Dorothy Stillson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karol Chapman Lukemire / wife 3510 Dublin Road; Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/23/07 Towson, MD 4 ☐ Donation 6 ☐ Other (Specify) 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home Approximate 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Years disease or condition resulting in death) Du to (or Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery edent pregnant 3 ☐ Ectopic pregnancy ast 12 months? 2 □ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2□ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 25. Was case referred to medical examiner? 1 Yes

Physician /Medical **Examiner**

Department of Important: If it any Injury or conce.

Physician

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Examiner

10a. State

MD

Funeral

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Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland

the Hospital or Attending Physician: The law requires that the death certificate be executed

Examiner

Physician/Medical

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Division or Vital Records, P.O. Box 68760,

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						1 Yes 2 No 1 Yes 2 No	
				26.	Place of Dea	th (Check only one)	
Но	ospital: 1 XInpatient 2 □	ER/Outpatient	3 🗆 DOA	Other: 4	☐ Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)	
1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c	Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred	
,	28e. Place of injury - At h building, etc. (Speci	ome, farm, street	t, factory, o	ffice		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
veí	cian: To the best of my kn	owledge death o	ccurred at	the time d	ate and place	and due to the cause(s) and manner as stated	Ī

29a.	Certifier
	(Check only
	one)

27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide 4 Homicide

> 1 Certifying Phy 2 Medical Even Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatur

2 JUL

5 ☐ Pending investigation

6 ☐ Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and a	address of t	PISOII	willo comb
Rodnes	, W	111	IAM

31. Date filed (Month, Day, Year)

eleted cause of death (Item 23a) (Type, Print) 6701 32. Registrar's Signature

N. Charles Street Towson, 21204

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Physician Division or Vital Records, P.O. Box 68760, Hospital or Attending

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Pages 1 and 2 should be filed within 72 hours after

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Registrar

29a. Certifier (Check only one)

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\$2. Registrar's Signature

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light pedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

BALTIMORE, MD

DO051737

29d, Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year MURRA RISTOPHER 4:55 2007 mons 19)UK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kirkwood RUAD 1675 BALTIMERE Wood Isun If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Year) 10 M 2 □ F Hours 218 77 1859 Director 2002 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d Inside City Limits 1 ☐ Yes 2 ☐ No BALTIMORK Director MARY/AND Wood LAWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be 1675 IR Knood 21207 USA iral", or items 23a Examiner must b Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Pages 1 and 2 should be filed within 72 hours after onent of Heatth and Mental Hygiene. In the train and the train and the train and the train and the Medical Examined by or other traumatic event, the Medical Examined my or other traumatic event, the Medical Examined. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ÎNo Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be YCE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD ROYCE permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra md 21207 mother BALTIMORR 1675 KIRKWOOD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □Removal from State 5 Other (Specify) MEMORIAL 4 Donation Wood ILWN, MARYLAND HARRIS FUNERA MOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore MARY 5240 ExistRestown 23a. Paris. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** 1 yelogenous /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if a.iy, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) nd title of certifier

Registrar

30. Name

31. Date filed (Mor

2401

dress of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please	Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible	
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State of Maryland / Department of Health and Mental Hygiene

		State Registrar	,	Ce	rtificate of I	Death	Reg	g. No.		
Db		1. Decedent's Name (First, Middle, Last,					Date of Death Month	Day Y	3. Time of Death	
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Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of	Death	
		Baltimore-Washingt			Glen E			Anne	Arundel	
Funeral		Social Security Number 6. Security Number	TM 21X E		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear)	Birthplace (State or Foreign Country)	
Director		216-18-9270	83	Yrs.			May 1,19	24	Maryland	
and www.t		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notitied at ance.		21. Signature of uneral service Licens		M	cCully-Po	lyniak Fu ain Road	neral Ho	me, P.A		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	nvestigation, in my o	pinion, death occurr	ed at the time, dat	ise(s) and manr te and place, an	d due to the cause(s)	
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1 4		30. Name and address of person who co	moleted cause of death. Item	17)() 123a) (Tyne	Print)	- 10	1 5	UL-7 1	0.2007	
4		DR DCANA FAIFA	5 LEV 70-11	50AL	A Kerry	IN. SE	not Colo.	Runai	e, MD ² /06/	
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	· VUCOUT	11116-11	- P	11)11 (1)1	5/1-10	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10b d.18 per fh 9869 7-23-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **18** 2007 ear JULY SYLVIA MERFELD 7:30 A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 7211 PARK HEIGHTS AVENUE #404 BALTIMORE N/A Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/14/1919 1□M 2√F Days Min. Months Hours 212-18-7422 87 Yrs. ۷A Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A -BALTIMORE BALTIMORE Yes Z 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7211 PARK HEIGHTS AVENUE #404 21208 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) SECRETARY FINANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOUIS COHEN MARY MEL-I COVE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE SHEAR / NIECE 14700 FIRESIDE DRIVE - SILVER SPRING, MD. 20905 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CONG: 07/20/2007 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic een Vascular disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? vascular discose 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown osteomyelitis 24b. Were autopsy findings available prior to completion of cause of death?
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/Medical Examiner Division or Vital Records, P.O. Box 68760,

and ed by the attending physician detached for use as the burial pe signed by the certificate has After this spital or Attendl nours after death. neral Director: ? To the Hospital of within 24 hours at To the Funeral D

Physician

Examiner

MD

Director

Funeral

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Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

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funeral director,

3altimore, Maryland 21215-0036

/Medical

State Registrar my

and manner stated.

32. Registrar's Signature

29c. License number

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Roggen 5400 Old Court Road

Rundallstown

MO 21133

Pasadena, MD 21122

■ Baltimore. Maryland 21215-0036 Division or Vital Records, P.O. Box 68760. State Registrar DHMH 17 Rev 1/2001

a		1. Decedent's Nan	me (First, Middle, L	ast)						2. Date of D		٧		. Time of Death
Physicia /Medic		Sand	dra Rache	l Montague						July		2007 Yea		5:40 p M
Examin		4a. Facility Name ((If not institution, gi	ve street and number)			4b. City, T	own, or Lo	ocation of Death	-	4	c. County of De		
		Greater I	Laurel He	alth and Re	ehab		I	aure.	1		F	rince G	eorg	ge's
Funeral Director		5. Social Security I 238–64–28		Sex 7. Ag 1 ☐ M 2 TF	e (In yrs. 66	last birthday) Yrs.	If Under		f Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth ay, Yea /194	9. B	irthplace Country)	(State or Foreign
D		Usual Residence o	т								, , , ,			
farylan show ed at	_	10a. State	10b. County	1		y, Town or Lo	cation							Inside City Limits
e Ma la-f s tiffiec	cto	MD	Prince G	eorge's	Bowi	Le								1X Yes 2 No
ith th or 28 e no	Director	10e. Street and Nu	umber				10f. Zip				10g. C	Citizen of What (Country?	
th wi		15207 Joh	hnstone L	ane			207					JSA		
r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		S. 13.	Was Decede	ent of Hisp fy Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - An Black, Wh		ndian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inpopratment of Health and Mental Hygiene. Inpopratment of Health and Mental Hygiene. In Inportant: If then 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ		rried 2□ Married 4ሺDivorced	1 XYes 2 □ I If Yes, Give Year or Dates:	No 1959	,	1□Yes 2	No	Specify:			Specify: Bl	ack	
72 ho	eted	(Spe	15. Decedent's E ecify only highest g	Education rade completed)		i (Give	dent's Usual	k done dui	on ring most of work	ina	16b.	Kind of Busines	s/Indust	ry
vithin tne. than "	Completed	Elementary/Sec		College (1-4or 5	5+)	life.	DO NOT use	e retired)	nseling	J		ounseli	na	
Hygie Ther I		17. Father's Name	e (First, Middle, Las	st)		TICS II	ICI1Ca±		8. Mother's Nam	e (First, Middl			119	
d be ental	To Be	Frank Mo							Ardener	, ,		·····-,		
shoul M M mar	-		Name/Relationship	(Type. Print)		19b. Mailir	ng Address	Street and	d Number or Rui	al Route Num	ber, City	or Town, State	, Zip Coo	de)
alth a 27 is		Anthony (C. Taylor	/ Son		16066	5 E. I	thaca	a Pl., A	urora,	co	80012		
s 1 a of Hear		20a. Method of Dis	•	_	20b. F	Place of Dispo	sition (Nam	e of	i	Date /2007	_	Location - City	or Town,	State
Page rent c nt: If			2 ☐ Cremation 3 5 ☐ Other (Spec	□Removal from State	Sal	instant Isbur	Nat	T Ce	12 07/22	/2007	Sal	isbury,	NC	
rmit. partn porta y inju		21. Signature of	uneral Service Lic	nsee		22	2. Name and	Address	of Facility Ren	don-Ba	ilev	Funera	l Ho	me. PA
89589		1/6w	lear to		MO145	2 28	318 E.	Balt	timore S	t., Ba	ltim	ore, MD	212	24
		23a. Part1. Enter shock, or he	the disease, or coleart failure. List onl	mplications that caused y one cause on each li	the deatl	h. Do not ent	er the mode	of dying,	such as cardiac	or respiratory	arrest,		Inte	proximate erval Between
Physician		Immediate Cause disease or conditi	e (Final ion	Resp	iral	tonu	Fall	110					On	set and Death
/Medical		resulting in death))	Due to (o as	a conseq	uence of)	1 44			- 1°	V			1
Examiner	.	Sequentially list of	conditions.	b. MRSAC	eve	britis	SIN	erun	goence	phali	TUS			
p	ine	Sequentially list of any, leading to i cause. Enter Und Cause (Disease o	immediate derlying	Due to (or as	a conseq	uence of):			U	N.				
ecute and -trans	Examine	that initiated evening in death)	ts e	C	2.000000	uanaa af\:								
De ex cian a		rooding in dodn'y		Due to (or as	a conseq	uence or):								
cate k	dica			d										
eath certificate be executed attending physician and for use as the burial-transit	cian/Medical	IF FEMALE:		23c. If yes, outcome	nf preams	ancy						20.1 7.1		
attene for us	ian	23b. Was decede in the past 12		1 □Live birth 4 □ Pregnant a	2 Feta	Ideath 3	⊒Ectopic pre ⊒ Other <i>(sp</i> e					23d. Date of o Month	lelivery Day	/ Year
	Physic	1 □ Yes 2 9 □ Unknow		9□Unknown	t time or u	eatii 5L	_ Other (spe	:City)						
w requires that the d been signed by the should be detached		Part II. Other sign	nificant conditions	contributing to death b	ut not res	ulting in the u	nderlying ca	use given	in Part I.	23e. Did	tobacco	use contribute	to the ca	ause of death?
uires sign Id be	d by	Renay	Failur	c, DM	, 17	fn,	Hyp	othu	uvoidisi	V) 1] Yes	2 ₫ No 3□	Probably	/ 4 □Unknown
v req beer shou	ete	HAD C M	Λ	1			,7,	()	24a. Wa	e an	24h Were	autoney	findings available
The larate has	Completed		/7							aut	opsy formed?	prior t	o comple ?	etion of cause of
		25. Was case refe	arrod to modical						0 Di (D	1□ Yes		No 1 □Y	es 2] No
	o Be	examiner?		Hospital: 1 Inpatie	ant 2 🗆	ER/Outpatier	nt 3 🗍 DO	Othor	26. Place of Deat			200	Y	20/00/0
Phys r this aral dii	-1	27. Manner of Dea		28a. Date of Inju	ıry	28b. Time o		Bc. Injury a Work?		28d. Describe		6 № 0ther (S)	oecity) T	KNWO
ding I th. After funer	tion	1 ☐ Natural 2 ☐ Accident	5 Pending investigation	(Month, Da on	y Year)	Injury	м		es 2∐No					
Attence death	fica	3 ☐ Suicide	6 ☐ Could not determine	a Zoe. Flace of Inj	ury - At ho	ome, farm, str	eet, factory,	office	1	28f. Location	(Street	and Number or	Rural Ro	oute Number,
al or safter	Certification:	4 🗌 Homicide		building, et	c. (Specif	у)				City or T	own, Sta	ite)		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director, completely filled in by the fu	Medical C	29a. Certifier (Check only one)	1 D Certifying F 2 Medical Exa	Physician: To the best aminer: On the basis o and manner st	f examina	wledge, deat ation and/or in	h occurred a vestigation,	at the time in my opin	, date and place, nion, death occur	and due to the	e cause e, date a	(s) and manner and place, and d	as stated	d. e cause(s)
To the within 2 To the comple	Mec	29b. Signature an	nd title of certifier	and marrier su			29c.	License r	number		29d. E	Date signed (Mo	nth, Day	, Year)
- 3 F 8		1 Ire	acy-ac	Jansen	M	>	D	006	2357			1271	07	

Magothy Beach Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Tracy A. Jansen

JUL 2 3 2007

31. Date filed (Month, Day, Year)

07-05407 Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

emel McMillian	1	1-For State of Maryland / Department of Health and Mental Physiene Certificate of Death	Reg. No.	
Physicia	_	Registrar 2 Date of	Death	3. Time of Death
edical Exami		remel McMillian July 15	5, 2007	0258 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of De	. /
	4	Ciriai i iospitai	of Birth(MM/DD/YYYY) 9.	Birthplace (State or
Funeral Director	1	217-08-0125 1Mm 2 F 2Z Yrs. Months Days Hours Min. Ma	For	reign Country) / / / / / / / / / / / / / / / / / / /
ń.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	,	10d. Inside City Limits
ow any		NAID BOLLOW		1 Yes 2 No
daryland 28a-f show d at once.	흥	5 10e. Street and Number 10f. Zip Code	10g. Citizen of What C	ountry?
he Ma 1 or 28 iffed 3	ᆲ	2418 Loyala North Way-Apt. 301 21215	08	4
with 1 ns 23s	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - Ar White, etc	nerican Indian, Black,
death or ite	F.	1 Yes 2 No	``	American
safter iral", niner	ᇗ	3 Wildowed 4 Divorced in res, sive real or pates:	16b. Kind of Busine	
2 hours afte "natural", I Examiner	eted	during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+)		
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner, must be notified at once	Comple	1245 Laborer		structur
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	Ŝ	17. Father's Name (First, Middle, Last)		
2121 ould be fi Mental I marked ic event,	Be		Number, City or Town, S	tate, Zip Code)
MD 2 d 2 shoul lth and M n 27 is m	۽	Ida N. Toy/mother 6 W. 2479 St. Ches	ster, PA 10	7013
ore, MD ss 1 and 2 sho of Health and If item 27 is	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date	20c. Location - Cit	y or Town, State
MOFE	ļ	1 Donation 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: King Memorial Park 7/20/0	7 Baltono	se County MD
Baltimore, Permit. Pages 1 and Department of Healt Important: If item injury or other tran	l	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	ray Servi	CR. P.A.
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato	acetimon	Approximate Interval
Physician Medical		failure, List only one cause on each line.	ry arrest, shoot, or from	Between Onset and Death
xaminer	- 1	Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) of head and leg Due to (or as a consequence of):		
		Sequentially list conditions, b.		
	iner	if any, leading to immediate Due to (or as a consequence of):		
9 -	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
Records, P.O. Box 68760, of The law requires that the death certificate be executed create has been signed by the attending physician and page 2 should be detached for use as the burial - transi				
60, ate be execut hysician and e burial - tra	Physician/Medical	UNPENDED AMENDED AMENDED	23d. Date of de	livery
876 ificate ng phy ss the b	n/M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Month	Day Year
Box 6871 death certifica the attending pled for use as th	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 7 1 Yes 2 No 9 Unknown	_	
O.O. Box 6876 that the death certifica need by the attending phe detached for use as the	hys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribu	te to the cause of death?
Records, P.O. The law requires that th cate has been signed by page 2 should be detach	by	<u>a</u>	Yes 2 ✔ No 3	Probably 4 Unknown
ds, equire	eted	24a.		re autopsy findings available r to completion of cause of
COF s law r s has b c 2 sh	Completed	1 V	performed? dea	
tal Re(cian: The certificate ector, page				
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	o Be	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home	5 Residence 6	Other:
Division of Vital Is the Hospital or Attending Physician: hin 24 hours after death, the Funeral Director: After this certifinpletely filled in by the funeral director,	- -	27 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work? 28d, Des	scribe how injury occurred t shot	
ion ttendi death.	atio	The second secon	ation (Street and Number	or Rural Route Number, City
Division Sepital or Attendir hours after death. meral Director: A	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Local or T 28g. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Local or T 28g. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Local or T 28g. Place of Injury - At home, farm, street, factory, office building, etc. 28g. Sidewalk	own, State) parman Avenue, Baltim	ore, MD
To the Hospital within 24 hours To the Funeral			e cause(s) and manner as	s stated.
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	e, date and place, and due	to the cause(s)
7 v v v v v v v v v v v v v v v v v v v	Me			(Month, Day, Year)
		O.C.M.E.	July 16, 200	/
1.		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD:	21201	
4		24 Date Flad (14 and Day Yoor) P Registrar's Signature		
S Regis	tate	123 O 0 2007 4 M Cased 1		

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

07-05493

Steven Joseph Maylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	<i>,</i> .			1.1. 1.1		1.1
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	State of Mar	viano / Deb	al lillelil Oi	Ticalli and	INICITICAL	riygiche

even oosepi iv	1	Registrar	ificate of Death			Reg. No.	1		
Physicia Iedical Examir	ın/	1. Decedent's Name (First, Middle,Last) Stephen J. Maylor			2. Date of De Month July 17,	Day 1	7ear 3. Time of Death 1600 hrs		
		4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Towr Baltimor	e, or Location of			ty of Death N/A		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	st birthday) If Under 1 Yrs.		24Hrs. 8. Date of Min. 8/22		YY) 9. Birthplace (State or Foreign Country) MD		
nd thow any <u>ce.</u>	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7 N/A	Fown or Location Balt	imore C	more City 10d. Insid				
ath with the Maryland trems 23a or 28a-f show ast he notified at once.	Dire	10e. Street and Number 1230 Hull Street	10f. Zip Co	212			What Country? USA		
or de	Fune	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced of Pates:	13. Was Decedent of If Yes, specify C	uban, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	W Speci			
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examine.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 1	16a. Decedent's Usual Oct during most of working Carpen	g life. DO NOT u			struction		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Con	17. Father's Name (First, Middle, Last) Louis Maylor		Nor		Ring			
AD 2 sho 27 is mati	٥	19a. Informant's Name/Relationship (Type, Print) Louis Maylor / Father	19b. Mailing Address (Street	, Baltimo	re MD 2			
(1)		1 Burial 2 X Cremation 3 Removal from State	Place of Disposition (Name rematory or other place) BayView Crema	tory		7 Balti	more, Maryland	. E	
		21. Signature of Furneral Service Licensee Victor P. Doda 23a. Part I. Enter the disease or complications that caused the death.	Charles 1501 E.	Idress of Facility L. Steve Fort Average Bying, such as ca	ens Funer enue, Bal Irdiac or respiratory	al Home timore	r heart Approximate Int		
Physician 'Medical aminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of		- 10-			Between Onset Death	t and	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	i):						
ficate be executed giphysician and the burial - transit	Examine	events resulting in death) Last Due to (or as a consequence of d.	f):						
760, cate be exect physician an	Medical	UNPENDED X AMENDED TIFM#1, pe	rME,G869,7/21/0	07.WS		Tools	As a find bline me		
ox 6876C ath certificate a attending phys		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Q Unknown	2 Fetal death	3 Ectopic	pregnancy	Mon	te of delivery th Day Year	r	
b.O. Be that the de ned by the detached f	by Phy	Part II. Other significant conditions contributing to death but not re	esulting in the underlying c	ause given in Pa			contribute to the cause of death		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Whe Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Completed				a	Vas an 2 outopsy erformed? 'es 2 No	Ab. Were autopsy findings ava prior to completion of caus death? 1 Yes 2 N	se of	
al Re an: Th ertifica	ပို	25. Was case referred to medical			(Check only one)				
f Vita Physici r this c	70 B	1 V Yes 2 No 28a Date of Injury	ER/Outpatient 3 DO 28b. Time of Injury 28	A Other 4 Co. Injury at Work	Nursing Home 5	Residence			
On O ending ath. or: Afte	tion:	1 Natural 5 Pending FOUND:		1 Yes 2 🗸	No Subject	drowned in h			
Division fallon Atterners after de la Directe	Certification		ome, farm, street, factory, o	office building, et	or Toy	on (Street and N wn, State) Hull Street , Ba	Number or Rural Route Number altimore , MD	r, City	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a and manner, stated.	ge, death occurred at the transfer investigation, in my control	ime, date and pla opinion, death oc	ace, and due to the courred at the time,	date and place,	and due to the cause(s)		
F. ½ § §	Me	29b. Signature and title of certifier		License number O.C.M.E.	OCME	July 18	e signed (Month, Day, Year) 3, 2007		
•		30. Name and address of person who completed cause or death (Item		on Street Da	altimore MD 21	1201			
2	State	Theodore M. King, Jr., MD. Assistant Medical 31. Date filed (Month Pay Pear 2007 322 Registrar's Signat		in Street, Ba	altimore, MD 21	1201			
Regis	قللته	JUL 2 1 2007 / Lever 2	The state of the s						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#23Pt II, PERPHYS, G869,7/23/07 WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2007 8 Day Month Physician Τ. Raymond North, Jr. 300M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** astor HOSDI 8. Date of Birth
July 15, 1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min. 1√□M 2□F 212-20-8461 82 Maryland Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Talbot Easton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 USA 37 Kensington Drive Funeral 12. Was Decedent Ever in U.S. Agmed Forces? *F∏Yes 2 ☐ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Completed by Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Megonee. Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Τ. North, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Sandra C. Grignon (Daughter) 109 Autumn Lane, Centreville, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/23/07 Baltimore, Maryland 4□Donation 5 ☑Other (Specify)Entombment 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityLoudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician us disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed 0 attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) signed by the a Id be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not sesuiting in 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 1□ Yes 21 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day 1/2 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 048064 July 18,2007 ompleted cause of death (Item 23a) (Type, Print)

Registrar

State

Stitely

Kevin

MD

32. Registrar's Signature

Ray mond

SOS DUTCHMANS LANE EASTON, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of N	/laryland / De	partment of H ertificate of I		ntal Hygiei	- 18 HI /	2348	
	Physic //Medi		1. Decedent's Name (First, Midd		ine		2	Date of Death Month	Day Year	3. Time of Death 4 S4 PM	
	Exami		4a. Facility Name (If not institution of the Company)	ical Cent	her er	4b. City, Town, or Balti	Location of Death		4c. County of Death	, 0, 1	
24	Funeral Director		5. Social Security Number 2/3/4/4/SU7 Usual Residence of Decedent	6. Sex 7. A	Age (In yrs. last birthda Yrs.	Months Days	Hours Min. 8	Date of Birth Month, Day, Yes		place (State or Foreign htry) Ny IND	
	Maryland -f show fied at	tor	10a. State 10b. Count	1/2	10c. City, Town or				1	0d. Inside City Limits Yes 2 □ No	
	with the Na or 28a-	al Director	10e. Street and Number 524 N. CH	ARIES Str	Ect # 171	10f. Zip Code	261	10g.	Citizen of What Cour	ntry?	
36	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4	If Yes, Give	140	3. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Specit n, Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Black	etc.	
1215-0036	nd 2 should be filed within aith and Merital Hygiene. 27 is marked other than " r traumatic event, the Me	Completed	(Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or	(Gi	cedent's Usual Occupa ve kind of work done of DO NOT use retired	luring most of working)		Rind of Business/In		
land 21		o Be Co	17. Father's Name (First, Middle I Mich W.	Last) Being S	.	och Dive	18. Mother's Name (F	First, Middle, Maid		whorn	
, Maryland			19a. Wormant's Name/Relation	ship (Type. Print)	19b. Ma	iling Address (Street a	and Number or Rural F	Route Number, Cit	y or Town, State, Zip	Code)	
Baltimore	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition Description 2 □ Cremation 4 □ Donation 5 □ Other (Specify)	cemetery, c	position (Name of rematory or other place CETY & frag 22. Name and Addres	P) 7/27		Location - City or To		
Ba	permit. Departr Importa any inje		21. Signature of Funeral Service	Couri		5240 Res	1 TErstown	1 RO AN		ang Molze	
	Physician /Medical	_	23a. Bart 1. Enter Me disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Ve	ntricula	1 tachy	card(a	espiratory arrest,		Approximate Interval Between Onset and Death	
8760,	Examiner	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	s a consequence of): s a consequence of): s a consequence of):						
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive	ry Day Year	
	quires that in signed b uld be deta		Part II. Other significant condition of the condition of		but not resulting in the	underlying cause give AilWe,	n in Part I.		obacco use contribute to the cause of death? 'es 2 □ No 3 □ Probably 4 ∰unknowr		
I Reco		Completed by	alcoholism	•				24a. Was an autopsy performed?	prior to cor death?	osy findings available inpletion of cause of	
or Vita	Physician: r this certifica ral director, I	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 Inpati			4 Li Nursing Home		6 ☐Other (Specify)	
Division or Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pendli investi 2 Accident 6 Could 4 Homicide 6 Could detern	not be 28e. Place of in	jury 28b. Time Injury njury At home, farm, setc. (Specify)	M 1 □ Y	es 2□No	Location (Street: City or Town, Sta	and Number or Rura	Route Number,	
Ω	Hospital of the hours af Euneral D tely filled in	Medical Cer	29a. Certifier 1 Certifyli (Check only one) 2 Medical	ng Physician: To the best	of examination and/or	ath occurred at the timinvestigation, in my op	e, date and place, and inion, death occurred	I due to the cause at the time, date a	(s) and manner as stand place, and due to	ated.	
	To the within 2 To the comple	Med	29b. Signature and title of certifie	and manner s	tated.	29c. License	number		Date signed (Month, I		
	4		30. Name and address of person	,	death (Item 23a) (Type		HIMAR	Manda	414,200	07	
	Sta Registr		31. Date filed (Month, Day, Year)	3 2007 32 egist	trar's Signature	male and	ti-frior(ju www y to			

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		1 - For Stete Registrar	State of Marylar		artment of H rtificate of L			ene		
Physi /Med		1. Decedent's Name (First, Middle, Last		orski			2. Date of Death Month	Day	Year	Time of Death
Exam		4a. Facility Name (If not institution, give Harbor Hospital	,		4b. City, Town, or Baltime	re	ath	4c. County o	f Death	
Funera Directo		5. Social Security Number 6. Se 219-60-7884 Usual Residence of Decedent	7. Age (In yrs. 53	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Year)	g. Birthplace Country) Maryla:	(State or Foreign nd
Maryiand I-f ehow	tor	10a. State 10b. County Maryland N/A	10c. Ci	ty, Town or Lo						nside City Limits Yes 2 □ No
th with the 23a or 28s	ai Direc	10e. Street and Number 1521 Cherry Street	et		10f. Zip Code 2122	26	10	g. Citizen of Wr U.S.A		
5-UU36 72 hours after death with the Maryland naturel; or Items 23s or 28s-f show diest Examinating at	by Funer	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	li li	Was Decedent of Hi f Yes, specify Cubar I ☐ Yes 2 No	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	Black,	- American In White, etc. White	dian,
Maryland ZIZIS-UUSO nd 2 should be tifed within 72 hours at lith and Mental Hygiene. 27 Is marked other then "naturel", or traumatic event, the Middigal Exem	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steelworker			orking 1	16b. Kind of Business/Industry Steel Company		
Viditor ould be fited Mental Hygaricked other natic event,	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Na						e (First, Middle, Maiden Sumame) Czaplinska		
DESTITITION CE, INIGINATION CILLID-UUSO permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Depentment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, the Middical Examination must be notified at		20a. Method of Disposition 120 Burial 2 Cremation 3 R	Mother)	1521 Place of Disposemetery, crem	Cherry St	treet,		Maryla: Oc. Location - C	nd 212: ity or Town, S	26 State
permit. Pa		4 □ Donation 5 □ Other (Specify) 21. Signature of Fune at Service Lions		Ãc	Name and Address Cully-Pol	s of Facility Lyniak 1	-23-07 B Funeral Ho Avenue, B	me P.A.		Maryland
Pnysiciar /Medica Examine		23a. P. A. Enter the disease, or complication, or heart failure. List only or in addition and the asse or condition resulting in death)	RESPIRATOR Due to or as a conseq	h. Do not ente y Failu uence of):	er the mode of dying	, such as cardi	ac or respiratory arres	St,	Appr	roximate val Between et and Death
ficate be executed to physicien and is the burial-transit	edicai Examiner	E-quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq	uence of): I Infa	rction					
To the Hospital or Attending Physician: The law requires that he death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown			23d. Date of Month		Year		
equires that en signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. A I CONOLIC CEYEBELLAY DEGENERATION 1 Ves 2 No 3 Probably 4 Unkn								
lor Attending Physician: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	Completed	25. Was case referred to medical						No 1	ore autopsy fir or to completion ath? Yes 2	ndings available on of cause of
hysicia nis cert i direct	To Be	examiner?	ospital: 1 Inpatient 2 🗆	ER/Outpatient	0.4	_	eath <i>Check only one</i> Home 5 Residen		(Specify)	
tending Pleath. lor: After ti	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe how			
pital or At ours after of erel Directifiled in by		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	/) 			28f. Location (Stre City or Town,	State)		te Number,
n 24 ho n 24 ho ne Fun	Medicai	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinate)	ician: To the best of my kno er: On the basis of examinat and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my opi	e, date and place inion, death occ	e, and due to the cau curred at the time, dat	se(s) and mann e and place, and	er as stated. d due to the c	ause(s)
To the within To the comp	Ä	29b. Signature and title of certifier VIUNURUO MI		*	4			J. Date signed (,
2 7		30. Name and address of person who con VEENA RAOMD 300	npleted cause of death (Item SOUM HAND)	23a) (Type, P	erint) eet Baltin	nore, Mi	aryland 2	1225		
St Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signal		1 4.					-

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Rick Pir a. Method of Disp 1 Durial 2 L 4 Donamon	nkham/somosition		VI IQIII				er's Name	, , ,	Maiden Surname Ffith			
a. Method of Disp 1 ☐ Burial 2 I 4 ☐ Donamon	osition Cremation 3 [19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod									
1 □ Buria! 2 I 4 □ Donayion	☑Cremation 3 [Π	20h F		Round Oa			uson, Mi	21 204 20c. Location - C	ity or To	win State	
	5 Other (Spec	☐Removal from Si	tate	cemetery, crei	matory or other	place)	07/20		Towson,	•		
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204												
23a. Pal 1. Enter the dibertle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
disease or condition resulting in death) Attherness Due to (or as a consequence of):											Onset and Deat	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.												
in the past 12	months?	1 □Live bir 4 □ Pregna	th 2 ☐ Feta nt at time of d	l death 3□							ery Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Yes 254No 3 Probably 4 Unkn												
								autop: perfor	sy pr med? de	ior to con ath?	psy findings avail npletion of cause 2 No	
examiner?		Hospital: 1 🗆 Inc	natient 2 🗆	FB/Outnatien	at 3□ DOA	Other				/Canaih	d	
Manner of Death 1 Natural 2 Accident	n 5 ☐ Pending	28a. Date of (Month)	Injury		28c.	Injury at Work?	4				//	
3 ☐ Suicide 4 ☐ Homicide		28e. Place o			eet, factory, of	ice	2			or Rura	l Route Number,	
a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	miner: On the bas	sis of examina	wledge, death tion and/or in	n occurred at the vestigation, in	ne time, date a my opinion, de	nd place, ath occurr	and due to the c	ause(s) and man late and place, ar	ner as st nd due to	ated. the cause(s)	
	tille of certifier	_ w.	, A-	the ad. h			0/6	2	9d. Date signed	i9,	Day, Year) 2007	
b. Signature and			of death (Item	701 A	Print) 1. Chevi	is st.	Sun 71	4105	n= HL	DIC	mo 21	
1 1 2 3 4 a.	Was case reference was case reference was case reference was miner? Was case reference was miner? Wanner of Death Suicide Homicide Certifier (Check only one)	Was decedent pregnant in the past 12 months? 1	Was case referred to medical examiner? Was case referred to medical examiner?	Was decedent pregnant in the past 12 months? 1	Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown II. Other significant conditions contributing to death but not resulting in the unit of line past 12 months? Hospital: 1 □ Inpatient 2 □ ER/Outpatier Hospital: 1 □ Inpatient 2 □ ER/Outpatier Hospital: 1 □ Inpatient 2 □ ER/Outpatier Wanner of Death Wanner of Death Wanner of Death Wanner of Death 28a. Date of Injury (Month, Day Year) Injury 28b. Time of (Month, Day Year) 28e. Place of injury - At home, farm, stream building, etc. (Specify) Certifier (Check only one) Certifier (Check only one)	Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause Was case referred to medical examiner? II. Yes 2 No Was case referred to medical examiner? II. Yes 2 No Was case referred to medical examiner? II. Yes 2 No Was case referred to medical examiner? II. Yes 2 No Was case referred to medical examiner? II. Yes 2 No Was case referred to medical examiner? II. Yes 2 No Was case referred to medical examiner? II. II. Inpatient 2 □ ER/Outpatient 3 □ DOA III. III. Inpatient 2 □ ER/Outpatient 3 □ DOA III. Was trial to the contribution of linjury and linjury with the underlying cause of linjury. III. Ves 2 No Was case referred to medical examiner: II. Unpatient 2 □ ER/Outpatient 3 □ DOA III. Was trial to the contribution of linjury and linjury with the underlying cause of linjury. II. Unpatient 2 □ ER/Outpatient 3 □ DOA III. Was trial to the contribution of linjury and linjury with linjury wit	Was case referred to medical examiner? Was case referred to medical examiner? Yes 2	Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome pf pregnancy 1 1 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 1 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to 1 Yes 2 No No No No No No No	23c. yes, outcome pt pregnancy in the past 12 months? 23c. yes, outcome pt pregnancy 1	Was decadent pregnant 1 cluse birth 2 Fetal death 3 Ectopic pregnancy 1 cluse birth 2 Fetal death 3 Ectopic pregnancy 1 cluse birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 2 Each 2 E	

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Maryland 21215-0036 I and 2 should be filed w lealth and Mental Hygier m 27 is marked other th Baltimore,

9:50

2007

Division or Vital Records. P.O. Box 68760. After this certificate has Hospital or Attending Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17 **Physician** HOWARD **POST** JULY G 2007 9:50 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u>STELLA MARIS HOSPICE</u> TIMONIUM
If Under 1 Year | If Under 24 Hrs. | BALTIMORE 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 094-46-6561 Months Hours 53 Yrs Director 05/04/1954 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD HARFORD FOREST HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 RACHAEL CIRCLE U.S.A 14. Race - American Indian 21050 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No WHITE Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISTRICT MANAGER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HYMAN **POST** HELEN SAMUELS ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau ELAINE POST 227 RACHAEL CIRCLE - FOREST HILL, MD 21050 / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State HIGHVIEW CEMETERY 07/20/2007 FALLSTON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** GASTROINTESTINAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) II Year 9.20PM **Physician** osephine m Rakowsky 2007 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Rehab hurs Burtonsville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex **Funeral** 194 12 55 89 1 M 2 F Yrs April 16, 1921 Pennsylvania 86 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Examiner must be notified at 1x Yes 2 No Director Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number è 20707 United States America 238 16115 Jerald Road Funerai 14 Race - American Indian Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2√ No Yes, Give White ò 1 ☐ Yes 2 X No Specify: Completed by 3 X Widowed 4 □ Divorced Year or Dates: "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Madical than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker other 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be l and Mental I (Last unk) Catherine John Shelava 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20707 16115 Jerald Road Laurel, MAryland Eileen M. Hall / Daughter item 27 I Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Importent: If it any injury or co 1 DxBurial 2 Depenation 3 Removal from State Arlington National Cemetery Aug. 16, 2007 Arlington, VA 4 □ Donation /5 □ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Funyral Service Licensee Van Fleck Funeral Home 7601 Sandy Spring Road Laurel MD 20707 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Onset and Death Immediate Cause (Final disease or condition resulting in death) SPIRATION PNEUMONIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transil Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 4 Onknown 1 ☐ Yes 2 ☐ No 3 Probably funeral director, page 2 should Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Mannet of Death 5 Pending investigation 11 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospitel or Attending Physicien: The law requires that the death certificate be executed the attending physician and P.O. Box 68760. Division of Vital Records, this After after death. filled in by 24 hours a Funerel (

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

completely within 2 To the State

IASN EEM

29b. Signature/and title of certifier

4 | Homicide

(Check only one)

29a Certifier

Medicai

Sugar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKHAM, 2835

29c. License number 28595

AYE,

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SUITE 203

32 Registrar's Signature 31. Date filed (Month, Day, Year) 2007

Registrar

SMITH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Nino Ridolfi soll 007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**☑** M 2□ F 215-44-2734 Director 70 April 26,1937 Italy Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ∐ Yes 2 1 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 23a 113 Glenmore Avenue 21228 item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Brick Laver Masonry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alberto Ridolfi Domenica DeGuissppe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other trau 113 Glenmore Avenue; Catonsville, Maryland 21228 Peitrina Ridolfi Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 7/23/2007 | Baltimore, Maryland 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Lemmer 1630 Edmondson Avenue: Catonsville 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Oronary disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran and attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) isigned by the ail 1 ☐ Yes 2 ☐ No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes Mo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760, Records, P.O. Vítal 0 Division

3altimore, Maryland 21215-0036

has within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 0 To the Hospital

Medical

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

29a. Certifier

29c. License number

McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

rson who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State Of Ivid	arylari		rtificate of			Re	g. No. 4 U	distribution of the state of th	ر ئ	1,9
	Physicia	an	1. Decedent's Name (First, Middle, Last)						M	ate of Death onth	Day	Year	3. Time of	
	/Medic	_	Angelo John Romeo				4h Oit Town			y 22,	2007 4c. County	of Dooth	5:12	Α ^M
	Examin		4a. Facility Name (If not institution, give st Gilchrist Hospice Ce		4b. City, Town, o		Baltimore							
-	Funeral		5. Social Security Number 6. Sex		e (In yrs. I	ast birthday)	If Under 1 Year		1 Hrs. 8. Da	ate of Birth fonth, Day,		9. Birth	place (State o	or Foreign
ŀ	Funeral Director			^{M 2□ F} 96		Yrs.	Months Days	Hours	Min. 4/1	0/191	Yea <i>r)</i> 1	Penns	ylvan:	ia
	land ow		10a. State 10b. County 10c. City, Town or Location										10d. Inside C	ity Limits
e Man a-f sh		ţo	MD Howard		E11	icott	City						1 ☐ Yes	2 ∑ No
	or 28% e not	ire	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cou	ntry?	-
	23a ust b	ral	3241 Old Fence Rd.				2104				USA			
036	should be filed within 72 hours after death with the Maryland of Mental Hyglene. The marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show maric event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1X Yes 2 ☐ If Yes, Give Year or Dates:		Ŧ	Was Decedent of In If Yes, specify Cub 1 ☐ Yes 2 ½ No		n? (Specify Y Puerto Rican	es or No- , etc.)	Blad	ee - Americk, White,		
Maryland 21215-0036	hin 72 ho e. an "natur Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation co <i>mpleted)</i> College (1-4or 5	i+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	of working	1	6b. Kind of B	usiness/Ir	dustry	
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חם	be file d oth even	Be	17. Father's Name (First, Middle, Last)								laiden Surnan	ne)		
$\frac{8}{5}$	2 should and Mer is marke aumatic	၉	Frank A. Romeo	- Drint)		10h Maili	ng Address (Street		aret V		City or Tour	Ctata Zi	a Code)	
<u>a</u>	2 ar ar ar		19a. Informant's Name/Relationship (Typ											
	s 1 and if Health item 27 other tr	1	Or. Frank J. Romeo/s 20a. Method of Disposition	SOII	20b. P		Greencr position (Name of matory or other pla		Date		ille, I		21030 own, State	
ē	e		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 🗗 Other (Specify)	moyal from State	it Lo	emetery, cre. rraine	e Park Ce	m. 7	/25/20	07 W	oodlaw	a, MI)	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	***	1442	2:	2. Name and Addre	ess of Facility	Harry 1	H. Wi	tzke's	Fami	ly FH	Inc.
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Stroke Due to (or as	e								Onset and	Death
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O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	ey .				ite of deliver		Year
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DIVISION OF VITA To the Hospital or Attending Physician:	I or Atten after deat Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	ome, farm, st	reet, factory, office				mber,					
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: , completely filled in by the f	Medical C	29a. Certifier (Check only one) Certifying Phys 2 Medical Examin		f examina									s)
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_	Htl		30. Name and address of person who cor	wes u	10 (0701	N. Ch	wles.	St P	NSU/	v m	2	1204	
F	Sta Registi		3. Date filed (Month, Day, Year)	32. Registr	ar's Signa	iture	2. 8° 2							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10d per fh 9869 7-23-07 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year **FLORENCE** RIVELIS JULY 2007 Р /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. BALTIMORE TOWSON If Under 1 Year If Under 24 H 8. Date of Birth (Month, Day, Year) 12/15/1926 Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F Hours 126-18-4485 80 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I fitem 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be in 2817 SAINT PAUL STREET 21218 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify. þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PLAINVIEW SCHOOL Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY SYSTEM s 1 and 2 should be filed w if Health and Mental Hygie item 27 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PINCUS SCHIMMEL MARTHA UNKNOWN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN RIVELIS / SON 2819 SAINT PAUL STREET - BALTIMORE, MD 21218 permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 20b. Place of Disposition (Name of ETERNAL LIGHT other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 07/20/2007 BOYNTON BEACH, FL. 4 ☐ Donation 5 ☐ Other (Specify) MEMORIAL GARDEN 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses <u> 8900 REISTERSTOWN ROAD - PIKESVII</u> MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician weeks disease or condition racrures resulting in death) /Medical Due to (as a consequence of): Examiner ununna Esquesitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit certificate be executed Exami Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the should be detached 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has page 2 autopsy 1□ Yes 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred MVLITTLE FALLS WHILE ATTEMPTING TO 28c. Injury at Work? After Hospital or Attending 5 Pending investigation 1 Natural JUNE 22 2007 UNKNOWN M 1 ☐ Yes 2 X No death. 2 Accident 3 ☐ Suicide AMBULASE after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide RESIDENCE - ASSISTED LIVING FACILLY 8911 Reisterstown RD BIRAMUR, MO To the Hospital within 24 hours at To the Funeral D **Decretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Decretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Decretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) the cause of rules ST BWON 31. Date filed (Month. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Stata Registrar	tate of M	aryland.		artment of I		and Mental	Hygier Reg. N		23496
	1 * 4		Decedent's Name (First, Middle, Last)						2. Date Mon	of Death	Day Year	3. Time of Death
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0	Examir		4a. Facility Name (If not institution, give stre				4b. City, Town,	or Location	of Death		c. County of Dea	_
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120	Funeral		5. Social Security Number 6. Sex	2 ☐ F	ge (In yrs. last 66	t birthday): Yrs.	If Under 1 Year Months Days		Min. (Mon	$\frac{1}{10}$	(r) C	rthplace (State or Foreign
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	/land		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	ours after death with the Marylan rel', or items 23e or 28e-f ehow Exeminer must be notilised at	to	MD Montgomery		Takom	a Par	ck					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10 g . (Citizen of What C	country?
	23a unit b		901 Fairview Avenue	#1			20912			US		
	72 hours after death with the Maryland natural', or items 23a or 28e-f ehow dras Exeminer must be notilled at	Funeral	T. Marian Glares	Was Decedent Armed Forces	?	13.	Was Decedent of f Yes, specify Cul	Hispanic Ori oan, Mexicar	igin? (Specify Yes n, Puerto Rican, et	or No-	14. Race - Am Black, Whi	
36	or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕅 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		1⊠Yes 2□No	Specify:	Mexican		Specify: Wh	ito
21215-0036	J within 72 hours piene. r then "natural", ine Madical Exe		15. Decedent's Educat		1	I6a. Dece	dent's Usual Occu	pation	HEATCAN		Kind of Business	
15	c * @	Completed	(Specify only highest grade of	ompleted)		(Give	kind of work done DO NOT use retire	during mos	t of working			
212	filed within 1 Hygiene. other then "	EO	Elementary/Secondary (0-12)	College (1-4or 5+	A	rchit	ect			Bu	ilding D	esign/Const.
2	be filed tal Hygid d other event,	Bec	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, A	Aiddle, Maid	en Sumame)	
<u>Ja</u>	D & 3 0	10					(unk)		*****			(unk)
Maryland	and and		19a. Informant's Name/Relationship (Type,			19b. Mailir	ng Address (Stree	t and Numbe	er or Rural Route	Number, City	y or Town, State,	Zip Code)
	eall eall		Susan Reyes Vasquez	/daught	er		airview	Ave.	#1 Takom		Location - City o	
Ore			20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Rem	oval from State	cem	etery, crer	natory or other pla					
Ë	tmen tant:		4 □Donation 5 □ Other (Specify)	1	Ches				07/20/07		ltsville	<u>-</u>
Baltimore,	permit. Page Depertment of Important: If eny Injury or once.		21. Signature of Funeral Service Kicensee	2/ /tt	_				ation Se			
ميوار			23a. Part1. Enter the disease, or complicat	ions that cause		$251B\epsilon$	everly L	Heck	rotte, P	A C	Larksvil	le, MD 21029
			shock, or heart failure. List only one of	ause on each I	ine.					,		Interval Between Onset and Death
3	Physician /Medical		disease or condition resulting in death)	>575			2H 60	<u></u>				Hours
	Examiner				a consequer	-	10					Naus
		e	Sequentially list conditions, if any, leading to immediate		a consequer							
1 1	uted d ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
0,0	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequer	nce of):						<u> </u>
8760,4	cate be executed physicien and the burial-transit	dlcal	d									
9	The law requires that the death certificate be executed tite has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Med	IF FEMALE:									
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome 1□Live birth	2 ☐ Fetal de	ath 3	Ectopic pregnan	су			23d. Date of de Month	elivery Day Year
0.	by the a	/sic	1 Yes 2 No	4□Pregnant a 9□Unknown	it time of deat	h 5L	Other (specify)					
٥	that if ed by detac		Part II. Other significant conditions contrib	outing to death I	out not resulting	ng in the u	nderlying cause g	iven in Part I	. 23e	Did tobacc	o use contribute	to the cause of death?
of Vital Records,	uires l signe	Completed by	Resnington Faile	rolle	utslux	bu I	epeno	1 ence	>	1 🗌 Yes	2 □ No 3 □ F	Probably 4 Junknown
Ö	w requ	ete	e de la santi	N. al.	10-111	all:	hel An	2:24	242	. Was an	24b. Were a	autopsy findings available
Rec	The lay	ш	En endobally!	10.	1.	tevi?	Dhow	12000	210	autopsy performed	prior to death?	completion of cause of
ā		e Co	25. Was case reterred to medical	e l'un	4 51	ure	ILIAC	A Diace	e of Death (Check	Yes 2 Z	No 1 ☐ Ye	s 2 No
=	Physician: r this certific ral director,	0 8	examiner? 1 Yes 2 No	pital:	ent 2 🗆 EA	VOutpatier	nt 3 DOA O	hor	ursing Home 5		6 ☐Other (Sp	ecify)
o	g Phy er thi	Į.	27. Manner of Death	28a. Date of Inj (Month, Da	urv 28	Bb. Time o	28c. Inju				jury occurred	
Ö	Attending I or death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(111011111)	, , , , ,	,,		Yes 2	No			
Division	al or Attendir s after death. I Director: Af d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home tc. <i>(Specify)</i>	e, farm, str	eet, factory, office	•		tion (Street or Town, St		Rural Route Number.
	rs aft	Cer										
	Hosp 4 hou Fune ely til	ical	29a. Certifier 1 Certifying Physic 2 Madical Examiner	: On the basis	of examination							
	To the Hospital or within 24 hours affer To the Funeral Dir completely filled in	Medical	29b. Signature and title of certifier	and manner s	iated.		29c. Licar	se number		29d I	Date signed (Mor	nth, Day, Year)
	Will To		De Ol	Do.	10	7	3	-) 1 X	550			
•			30 Name and address of person who comp	plated source of	death /Itom ?	3a) /Tubb	Print)	7 1 3		0.	-7 /	
	5		Name and address of person who comp	MA W	203	DU-2	ORSSU	dy (le Hyai	Uso.	He M	2007
	St.	ate	31. Date filed (Month, Day, Year)	7. Regist	rar's Signatur	θ 6	120	1				
	Regist		JUL 2 1 2007	Maria								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:09* W Lawrence Ignatius Stouter July 21 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimar Kaltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 213-16-0906 Director 92 1, Feb. 1915 MD Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 5272 Reisterstown Road 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lift Truck Mechanic Forklift Production marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental ۵ George Stouter injury or other traumatic Esther Pecher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Lucy Stouter 5272 Reisterstown Road, Baltimore, MD 21215 Wife Item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important; If Its any injury or o 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 7-25-07 Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road ausin ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUOCARDIAL Inforction Physician 0 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, ner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Exami and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of degree þ. Mell 1 🗌 Yes 2 🖺 No 3 ☐ Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient ٩ 1 Inpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier

Medical

1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tipe of g

2007

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause 6 death (Item 23a) (Type, Print)

cmuth rancis

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Registrer Amend #1, perMD, g869, 7/23/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) Clarence H. Slaughter, Jr. 3. Time of Death 2. Date of Death Month **Physician** 401 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 9950 Oaklea Court Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ▼ M 2 □ F Yrs. Director 224-05-5934 85 Sept. 9, 1921 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner hast be notified at Director 1√ Yes 2 No Maryland Howard Ellicott City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 9950 Oaklea Court 21042 or Items 23a United States America Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No unk If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: à B1 ack Specify: 3 Widowed 4 Divorced 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wi f Health and Mental Hygien tem 27 Is marked other th Microbiologist Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Slaughter Hazel Claiborne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If item 271s. 9950 Oaklea Court Ellicott City, Maryland 21042 Leon Slaughter / Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Crownsville Veteran Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 18, 2007 Crownsville, MD 4 ☐ Donation 🦒 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No Division of Vital 1 Yes 2 NO 1 Tyes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one) examiner' Other: 4 Nursing Home 5 Residence 6. Other (Specify) Hospital: 2 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide filled within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Back King Nece Road Bal ame and ad less of lerso, who completed cause of death (Item 23a), ype, Print) Manch Janapathi 101-10

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			. 101	artment of Health and Mer rtificate of Death	ntal Hygiene	7 2.495
	Physici /Medic	100	1. Decedent's Name (First, Middle, Last) Lennie	2.	Date of Death Month Day Year	3. Time of Death
F	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 5. Social Security Number 284-20-4184 6. Sext 7. Age (In yrs. last birthday, 1 Im 8 2 F 81 Yrs.	4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. M	4c. County of Dea 4c. County of Dea 4c. County of Dea 4c. County of Dea 9. Big (Month, Day, Year) ay 3, 1926	ath rthplace (State or Foreign outpry) K Y
	how at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	with the Marylan a or 28a-f show be notified at	Director	MD Baltimore Gran 10e. Street and Number 10109 Davis Avenue	nite 10f. Zip Code 21163	10g. Citizen of What C	•
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the Medical Examinar must be notified at	by Funeral		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- an, etc.) 14. Race - Am Black, Wh	erican Indian,
21215-0036	vithin 72 hours nne. .han "natural"; ne Medical Exa	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation be kind of work done during most of working DO NOT use retired) Li Manager	16b. Kind of Business	s/Industry
Maryland 2	nd 2 should be filed within aith and Mental Hygiene. 27 Is marked other than " r traumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) Henry Clevenger	18. Mother's Name (Fi	Grocer rst, Middle, Maiden Surname) ia Wells	y
	and 2 sho ealth and I n 27 is ma		Mrs. Patricia Douglass (Daughter) 103	ing Address (Street and Number or Rural Ri 109 Davis Avenue, Gr	· ·	Zip Code)
Baltimore,	nit. Pages 1 and 2 bartment of Health s ortant: If item 27 is injury or other tra			osition (Name of Date matory or other place) nonsus Cemetery 7/24		
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee Buax L. Huist Moo764	ANTGHT FUNERAL HOME Sykesville, MD 21784	& CHAPEL, P.A. (410)-795-1400	(Box 195)
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	ter the mode of dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between Onset and Death
68760,5	Medical Examiner bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Scleroder Due to (or as a consequence of):	Hypertension ma	7	1 years
.O. Box	requires that the death certifi een signed by the attending I nould be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	elivery Day Year
Δ.	w requires that been signed b should be deta	۾	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☒ No 3 ☐ F	to the cause of death? Probably 4 Unknown
Division or Vital Records,	The law ate has b page 2 sh	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Ye	
Vita	sician; certific irector,	Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 No inpatient 2 □ ER/Outpatle	26. Place of Death (Cont. 3 DOA Other: 4 Divising Home		
on or	Attending Physician: r death. ector: After this certific. by the funeral director, I	tion: To	27. Manner of Death 1 Poly Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of In	THE PORT AT INDISING HOME	5 ☐ Residence 6 ☐ Other (Sp Describe how injury occurred	ecify)
Divis	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fun	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f.	Location (Street and Number or F City or Town, State)	Rural Route Number,
	he Hospir in 24 hour he Funera pletely fille	Medical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and nvestigation, in my opinion, death occurred a	due to the cause(s) and manner a at the time, date and place, and du	as stated. ue to the cause(s)
	To the To the Complex of To the To To To To To To To To To To To To To	Σ	29b. Signature and title of certifier	29c. License number RES-000	29d. Date signed (Mon	
			Jasika Woreta, Medical DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type		JULY, 21	, 000.7
	Ċ		Fasika Woreta, 600 North Wolfe S	•	MaryLand 2	1287
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Perparinfers of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 12:40 PM JULY 2007 Gwendolyn Sewell 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death L-to SPITAL, 900 S. CATIN AVE AGNES BACTEMORE, MD, 21228 None If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 16 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 X Maryland 215 30 0816 73 Jan 1, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1310 Dorchester Avenue 21207 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Jacobs Gwendolyn Allsopp 19a. Informant's Name/Belationship (Type. Print) Gerald P. Sewell Sr. Jerry P. Sewell/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 Dorchester Ave. Catonsville, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem. Gard. 7-25-2007 Marriottsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 METASTATIC DAYS Due to (or as a consequence of) Sequentially list conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

GWEN BOLYN

Division or Vital Records, P.O. Box 68760

attending physician for use as the buria director, page 2 should Hospital or Attending Physician; funeral within 24 hours after death To the Funeral Director:

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

Physician

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death

Maryland 21215-0036

Baltimore,

Director

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

Completed

Be

Certification: To

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

MD

State Registrar

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

21227

900. S. CATON AVE.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIDHAR BADLKEDOT St AGNES HOGPUAL

and manner stated.

31. Date filed (Month, Day, Year) 32, Registrar's Signature JUL 2 3 2007